Volume 4, Issue 1

# Polio Oz News

March 2014—Autumn Edition

## In Case of Emergency . . .

Last year I found myself in a very vulnerable and frightening situation. I was in the hospital in great pain, minutes away from emergency surgery and facing an anesthetist who, when asked by my husband and me to read a brochure prepared by Polio Services Victoria on the issues facing polio survivors and respiratory issues, rolled her eyes.

How did we get to this situation? As a young teenager I was told by my physiotherapist, Mrs Jocelyn Towns, that mainstream doctors were unlikely to know much about my condition so it would always be up to me to educate them. I accepted this as just another hazard of having polio, which I had contracted at 6 months.

She was right. Much later it took many years for me to have post polio syndrome diagnosed. The mainstream doctors rarely asked about my (obvious) polio and I was diagnosed with a variety of other conditions. It was my own investigations that led me to a doctor who is well acquainted with post polio, and back to the specialist polio service, much depleted in resources since I was a child talking to Mrs Jocelyn Towns.

Since being diagnosed with post polio syndrome, I have been provided with a wallet sized "polio information card" that polio self help groups have developed with short-hand essential post polio information to provide to doctors we are being treated by. I have often wondered who will read such a card and under what circumstances. I have found it hard enough to discuss the post polio implications with doctors when I'm fully awake and alert as I have found that doctors are not always receptive. Will anyone notice and pull this card out of my wallet if I'm hurt in an accident and unconscious? Or is it something that can only be useful if I can hand it over and explain? It is just not reasonable to expect the patient to take this much responsibility for educating doctors. Furthermore, even if I take this responsibility upon myself, it won't be effective if medical staff are unaware of or not interested in the complex issues involved.

In 2011, I became aware of an unexpected, and poorly explained, death in a large public hospital of a man with post polio. Post Polio Victoria Inc. an advocacy group with which I am involved worked with his partner to follow up the case. A reason for his death was given as "post polio" and there seemed to be many unanswered questions, the main one being how did the hospital staff miss noticing his declining health, while continuing to inform his partner that he was progressing well. His partner had been concerned about his health, raising the issue of post polio but received continued reassurance until one day when she was suddenly informed that he was being rushed to the Intensive Care Unit. He died the next day and subsequently it seems that the main factor was an undiagnosed respiratory condition. (See *"Medical Misadventure"* in Polio Oz News, Winter 2012.)

Subsequently that hospital did develop a protocol, a "clinical alert" that will be attached to the file of any patient being admitted who identify that they have a history of polio. This is a great step forward. It places a responsibility for discussing the post polio issues on the hospital staff, rather than just relying on the patient.

So it is with this knowledge and experience I attended this other hospital, fortunately with some knowledge about my post polio issues. I was a bit nervous but I had my husband with me to advocate on my behalf. Throughout the assessment in the Emergency Department, we ensured that each new nurse or doctor understood that I had post polio. When faced with the reluctant anesthetist I felt anxious and powerless. I was in pain.

***Cont'd P 10***

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## Inside this issue:



## From the Editor

*Mary-ann Liethof*
*Editor*

I have been kept very busy organising a bevy of amazing session presenters for this year's Health and Wellness Retreat (see pages 6/7), as well as getting ready for Canberra (again) and putting together this edition of Polio Oz News! There are always so many articles that interest me - and I hope you're finding them just as interesting . . .

I am also getting ready to attend the two international Post Polio conferences coming up in May/ June this year. I hope to be presenting on how effective Polio Australia's Retreats are in increasing 'Health Literacy'. Post-Polio Health International (PHI) will be holding its 11th International Conference from Saturday 31 May to Tuesday 3 June in St Louis, Missouri, USA, in 2014. The theme of this conference will be *"Promoting Healthy Ideas".* Check out the conference Program here.

Post Polio Syndrome: A Condition Without Boundaries is the 2nd European Polio Conference and will be held in Amsterdam from 25-27 June 2014. Anyone thinking of visiting Amsterdam should check these "12 Wheelchair Accessible Tips".

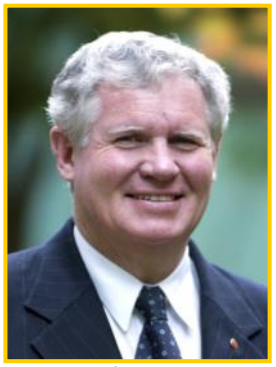
I intend to be regularly uploading information on my experience of these conferences on Polio Australia's website, so stay tuned! The cost of getting there is largely being supported by various fundraising efforts, for which I am very grateful!

Onwards and upwards!

## Letter to the Editor

Thank you for the article *"The Christmas of 1951: A Polio Story"* by Bill Peacock, polio survivor, in your December newsletter. I found his story very interesting and something I can easily relate to, although with a few tears in my eye. I too, got polio in 1951 at age 3 but I was hospitalised in the old Children's Hospital at Camperdown in Sydney. I am now 65. Like Bill, I also remember the dedication of the nurses, the singing of Christmas carols, some children not making it etc. I still have vivid memories of it. But I ended up a lot luckier than most. Although I have some muscle wastage in my legs, at least I can walk, unlike some polio sufferers. When I read Bill's story it reminded me to get out a children's book which was given to me by my infants teacher in 1953 when she came down to my parents house after school to read it to me. It still has her personal message to me written inside the cover. As well as the dedicated nurses, she was a very dedicated teacher. Although I was out of hospital I still was unable to attend school at that stage. Out of all my childhood memories I cherish that book more than any other possession. I often show friends the book as it means so much to me. My only regret in life is that I never tried to make contact (I never knew how to) with the teacher (Miss Kay) when I became an adult, to show her I made it, as some thought I wouldn't. I would have loved to show her that I still had her book. And at my age now, I have no doubt left it too late. A big regret in my life. Once again thank you for the story which certainly brought back memories (some good, some bad) for me.— *Wayne Milford (NSW)*

## From the President



*Dr John Tierney*
*President*

We are rapidly approaching that time of year when Polio Australia holds its *Annual Health and Wellness Retreat*. I would like to particularly thank Mary-ann Liethof for her tireless work in yet again putting together another world class program. This year we are holding the retreat in Sydney in early May and the details are in the following pages. I would really encourage you to go because in a relatively short period of time you will pick up so much about how to self-manage the LEoP condition. I have been to all four retreats that have been held so far in Australia and every time I pick up new knowledge and strategies from professionals and peers to assist me with the management of my polio body.

The three musketeers of Canberra lobbying (Gillian, Mary-ann & John) will be off to Canberra next week to heighten government and MP awareness of the LEoP condition and to continue our campaign for dedicated funds to assist polio survivors for our difficult life journey. Last year I was told that we were on the incoming Health Minister's wish list, but of course the Federal Budget conditions in 2014 are the toughest in decades. The centrepiece of our campaign will be the morning tea that we will be attending hosted by the *Federal Parliamentary Friends of Polio Survivors.* This will provide us with a platform for delivering our central message on the need for funding for targeted specific assistance programs for polio survivors.

At the function we will be presenting special plaques to our five (bipartisan) Parliamentary Patrons and providing them with an opportunity to speak. So far in the federal parliament over the last six years, sixty-one members and senators (25%+) have either joined our Parliamentary Friends of Polio Survivors group, or agreed to see us, or come along to one of our events or spoken in the Parliament about the needs of Australia's 400,000 polio survivors. This is a far cry from when we first went to Canberra in 2007, when one MP said to us, *"Polio, didn't we fix that fifty years ago?"*

Our work on re-establishing our historical links with Rotary continues. We now have an expanding group of polio survivor speakers garnering support from Rotarians for the formation of a new partnership between Rotary and Polio Australia's work in assisting polio survivors. I recently spoke to the *Cessnock Rotary Club* in the NSW Hunter Valley. In the following weekly club report the President David Clark wrote: *"Wouldn't it be great if Rotary and Polio Australia joined in a genuine partnership to expand the already unparalleled Rotary story of eliminating polio throughout the world with the addition of* ***closing the loop by helping the many polio survivors?"***

This is a splendid vision and I think that we have found a new catch cry! A complete report of David Clark's comments appear on page 4 in this newsletter. At the national level, our consultant Glenn Gardner AM, continues to nurture the joint Rotary / Polio Australia joint Steering Committee set up by the Rotary Governor's Institute to explore the establishment of a foundation for the ongoing support of polio survivors. I hold great hopes for this new partnership.

*John*

***Dr John Tierney OAM***
***President and National Patron***
***Polio Australia***

*The original 'Musketeers" in June 2009 with The Hon Peter Dutton MP, then Shadow Minister for Health.*

*L-R: Neil von Schill, Mary-ann Liethof, John Tierney, Gillian Thomas, Peter Dutton, and Peter Garde.*

## President's Report *(cont'd from p3)*

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# PRESIDENT'S REPORT

When Franklin Roosevelt contracted polio in 1921, at age thirty-nine, it inspired his interest in medical philanthropy. Hugh G Gallagher wrote "From the first, Roosevelt seemed to understand that rehabilitation of the polio patient was a social problem with medical aspects. It was not a medical problem with social aspects".

We were gifted last Thursday night to listen to the story of a polio survivor who has achieved greatly, when Dr John Tierney OAM told in graphic detail of his journey in life as a polio survivor having contracted polio at birth. We were confronted with the social and the deeply personal issues associated with polio. Who was not moved when confronted with the reality that a polio survivor will never be better than they are today and can only look forward to deterioration in their motor neurone functions? But in spite of this daily reality for him, to have given so much of his life to helping others (and still doing it) is a testament to the qualities of this great man. What a blessing it is to have known this man who has demonstrated the reality of service above self. Thank you John for taking the time to share with us your most significant story.

Wouldn't it be great if Rotary International and Polio Australia joined in a genuine partnership to expand the already unparalleled Rotary story of eliminating polio throughout the world with the addition of closing the loop by helping the many polio survivors?

**Dr John Tierney with President David.**
We all learned a great deal about Polio last week. John gave us a personal as well as an overall view of the Polio virus.
Not many of us realised that it was an ongoing problem that will get worse as they get older. I was amongst those who thought that once you took the vaccine, you were cured. The truth is anything but that. A media campaign is required to inform all the polio sufferers in Australia, as to ongoing treatment in their lives. This will cost a lot but it is vital that this message gets across to the many polio victims in Australia and around the world.

*Click on this link to see this edition of the Rotary Club of Cessnock newsletter.*

## Suzie's Queensland Rotary Campaign

Still on the subject of Rotary talks, Queensland-based polio survivor, Suzanne MacKenzie, is running her very own *"We're Still Here!"* fundraising campaign at Rotary Clubs up north. Sue's goal is to raise $50,000 to support Polio Australia's work, and she is already well on her way, having already raised a few thousand from the Rotary Clubs she has spoken to so far, which include:

Saturday 22nd February – Rotary Club of Cairns
Tuesday 25th February – Rotary Club of Townsville South West
Friday 28th February – Rotary Club of Cairns (mixed RC meeting)
Wednesday 5 March – Rotary Club of Mareeba
Friday 7th March – Rotary Club of Cairns Mulgrave
Tuesday 11th March – Rotary Club of Townsville

Sue is enthusiastically sharing Polio Australia's message that there are many thousands of polio survivors living in Australia who are missing out on appropriate health services and support due to a lack of informed health professionals, and there is no government, or any other regular funding provided to address this knowledge gap. With adequate funding, Polio Australia would not only run its current programs more efficiently in regards to community/patient education, it would also facilitate the development of a raft of other innovative programs to ensure Australia's polio survivors are well supported. So good luck, Sue. Polio Australia is glad to have you on our 'team'!

**Rotary Clubs who would like to book a Speaker can contact Mary-ann on Ph: 03 9016 7678 or office@polioaustralia.org.au and she will attempt to provide a link.**

## Suzie's Story

My name is Suzanne MacKenzie. I contracted polio at age 2 in 1948. I missed a lot primary school as I had many operations to alleviate the effects of polio on my right leg. My primary school lunch hours were taken up with physiotherapy. I had to wear a calliper until age 13. By this time I found the extensive operations and physiotherapy were allowing me to lead a reasonably active but hardly 'normal' life.

I managed University Entrance and, spurred by my extensive experience in hospitals, I determined on a nursing career. My application was denied because of my disability. I was devastated. I was, however, accepted to Teachers College where I graduated.

Fast forward to 2013 now aged 67. Married 46 years with 3 (married) children and 8 grandchildren. In the last 5 years I've been having falls rather than just tripping. They happen out of nowhere, one minute I'm standing, next I'm on the ground. I had a particularly nasty fall breaking an arm last year which kept me in hospital for a week.

Overall I found medical professionals had little understanding of the late effects of polio. They sent me to expensive podiatrists and physiotherapists who also have little understanding of the late effects of polio.

Finally I found Polio Australia and discovered there were many other polio survivors who were also falling over 50 or so years after contracting polio. We are no longer OK but we are still here and we do want to live as 'normal' a life as possible.

*Sue MacKenzie (right) accepting a very generous cheque for Polio Australia from Denise Mitchell, President of the Mulgrave Rotary Club, Cairns*

From the information available, it appears that the parts of our bodies affected by polio after 50 years of hard work compensating for the effects of polio, are now are ageing at an accelerated pace, and struggling to cope. Many of us are also becoming increasingly more disabled.

But now our cost of living is becoming higher with the need to access more health care, repair damage from falling, invest in expensive footwear, limit physical activity (taxis instead of walking), etc. And we, the survivors, medical professionals, and government need to know more about the late effects of polio, all of which requires funding. **We are still here and we do need a hand!**

# 2014 Polio Health and Wellness Retreat

Polio Australia ran its first Health and Wellness Retreat in Baulkham Hills, New South Wales (2010), with a second in Mt Eliza, Victoria (2011), a third on the Sunshine Coast, Queensland (2012), and the fourth in Glenelg, South Australia (2013). These were all based on a Polio Retreat held by Post-Polio Health International in Warm Springs, Georgia, USA (2009), which was attended by five Australians – four being polio survivors.

The Warm Springs Retreat focused on 'Body, Mind, Spirit' and this theme has also proven to be a very effective framework for our Australian Retreats, as it takes a holistic approach towards Chronic Condition Self Management for polio survivors, their families and carers.

Polio Australia's Health and Wellness Retreat 'open circle' Question and Answer format is a valuable self-management tool – especially the sharing of experience by the participants. The forums fully engage all participants in free-flowing discussion and information exchange, resulting in a clearer understanding and better retention of the management strategies being presented.

The knowledge gained during these Retreats has not only assisted participants to better manage their own condition, but is also being shared with their health professionals, thereby facilitating improved care for other patients presenting with the Late Effects of Polio.

This fifth Retreat is back where it all started, at the peaceful sanctuary that is St Joseph's Centre for Reflective Living. It promises to build on previous sessions and participant feedback to present a range of self-management techniques which will enable participants to achieve general wellbeing, as well as providing options for people to remain as mobile and independent as possible.

A summary of the days activities can be seen below, and a full Program and Presenters List is available here. Please note that this is still being finalised and some minor changes may be unavoidable.

**Thursday**
Registration and Welcome Dinner with Guest Speaker Paul Galy talking about his book *"The 4th of May: The Memories of Paul Galy OAM"*

**Friday**
Plenary - The Polio Body with Dr Stephen de Graaff

*Concurrent Sessions*

10.30 am to 12.00 pm
- Post Polio Exercise Options
- Functional Footwear
- A Breath of Fresh Air: how to work with your respiratory system to maximise speech and swallowing functions
- Pain and Fatigue Management

2.00 to 3.30 pm
- Osteopathic in Self Care
- Swollen Polio Legs
- Too Tired To Breathe?
- Managing Arthritis and Osteoporosis
- Partnering Polio

4.00 to 5.30 pm
- Mindfulness: What Is It And How Can It Help Me?
- Pain and Fatigue Management (Repeat)
- Avoiding Falls
- Nutrition
- Taking Charge of Your Own Health

**Saturday**
Plenary - Healthy Brain Ageing with Dr Loren Mowszowski

*Concurrent Sessions*

10.30 am to 12.00 pm
- Seated Yoga
- Early Polio Memories
- Singing for Fun!
- Mind Matters

2.00 to 330 pm
- Telling Your Story
- A Family History Taster: Catching The Bug!
- Cryptic Crosswords
- Travelling Options for People Ageing with a Physical Disability
- Partnering Polio

4.00 to 5.30 pm
- Card Making
- Making the Most of Our New Reality
- Laughter: The Best Medicine
- Bonsai Magic

Sunday
Plenary - The Healthy Spirit with Sister Annie Bond

*Concurrent Sessions*

10.30 to 12.00
- Awakening the Creative Spirit Within
- Philosophically Speaking
- Meditation

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## 2014 Polio Health and Wellness Retreat *(cont'd from p6)*

There will also be:

displays from
- Barefoot Freedom - orthopaedic shoes
- Independent Living Centre NSW - aids and equipment
- AutoMobility - accessible vehicle options

consultations and therapy treatments from
- Dr Steve de Graaff on self-management
- Dr Helen Mackie on lymphoedema
- Carole Gridley and Aruna Ellis - massage therapy
- Rudo Makuyana - podiatry appointment
- Heena Raikar - hands/feet aromatherapy

*and*

entertainment from
- Circular Keys Chorus
- Tommy Dean - Comedian

Bookings are now open and Registration Forms containing all relevant information and contact details can be downloaded from Polio Australia's website here.

*2010 Retreaters at Baulkham Hills*

To ensure that the Retreat environment is conducive to friendly networking, **numbers have been restricted to 70 people**. Preference will be given to New South Wales residents and those interstate people who have not attended previous Retreats. This does not preclude previous participants from registering and paying.

Bookings are only confirmed when payment is received and places allocated. Once we reach capacity, people will be contacted and asked if they wish to be placed on a waiting list. If we exceed the quota, once places have been allocated, there will be an immediate refund of payment.

***Note:** this Retreat is a fully residential experience and there is no 'day only' option.*

## Supporting Polio Australia

**Polio Australia would like to thank the following individuals and organisations for their generous support from 1 December 2013 to 28 February, 2014:**

### Hall of Fame

| Name | Donation |
|---|---|
| John Tierney | $1,000 |
| | |
| **Total - $1,000** | |

### Significant Donations

| Donation - General | | |
|---|---|---|
| Anonymous | Lions Club of Medowie | J & H Raeburn |
| B Bencina | M & A O'Connor | Prof D Small |
| J Burn | M Owens | J Smith |
| J Caldwell | Dr G Parslow | M Wilson |
| Assoc Prof R Day | G Pearson | |
| Dr J Feldman | J Pickering | |
| **Total - $2,242.10** | | |

### Fundraising Campaigns

| Name | Donations - Walk With Me |
|---|---|
| *"Melbourne Meander"* Team (Total) | $5,144.15 |
| *"Parramatta Promenade"* Team (Total) | $8,165.00 |
| | |
| | **$13,309.15** |

| Name | Donations - Rotary |
|---|---|
| Rotary Club of Goodna (NSW) | $1,000.00 |
| Rotary Club of Williamtown (NSW) | $200.00 |
| Rotary Club of Kew (Vic) Bunnings Sausage Sizzle | $1,200.00 |
| | |
| | **$2,400.00** |

### Become a Friend – Invest in Polio Australia and Make a Difference

Please invest in Polio Australia's work to help ensure that all polio survivors in Australia have access to appropriate health care and the support required to maintain independence and make informed lifestyle choices.

**Polio Australia is endorsed by the Australian Taxation Office as a Health Promotion Charity and a Deductible Gift Recipient making all Australian donations over $2 tax deductible. Polio Australia will issue an official receipt for all donations received.**

Your Donation can be made via any of the following methods. Click here to see all the options.

***Thank you for investing in us to make a difference – every donation helps polio survivors***

# "Understanding the Late Effects of Polio" Training

On the 20th of February this year, Polio Australia facilitated its first *"Understanding the Late Effects of Polio"* workshop for 23 health professionals at MS Australia's training facility in Blackburn (Victoria). This three hour session was designed to explain the Late Effects of Polio (LEoP) and Post-Polio Syndrome (PPS) and to explore practical strategies to help post-polio clients to stabilise and improve their symptoms.

The session presenters were:

**Dr Stephen de Graaff, Senior Rehabilitation Physician and Director of Pain Services, Epworth Healthcare**
Dr de Graaff has been diagnosing PPS and working with post-polio patients since 1995. He provided a general introduction to the Late Effects of Polio and Post-Polio Syndrome including symptoms, diagnosis, cause, incidence, treatment options and current research.

**Louise Thomson, Senior Physiotherapist, NeuroMuscular-Orthotics**
Louise previously managed Polio Services Victoria at St Vincent's Hospital, Melbourne, and continues to consult with post-polio clients at NeuroMuscular-Orthotics. She presented practical strategies used by physiotherapists, orthotists, and various other allied health professionals to address key concerns such as managing pain and fatigue, and help with stability and avoiding falls.

**Natasha Layton, Occupational Therapist**
Natasha specialises in assistive technology and environmental interventions. She has worked with diverse populations in rehabilitation and community settings over the last 20 years. Natasha's research area is the use and outcomes of assistive technology and other enablers, and she works collaboratively with Victoria's Aids and Equipment Action Alliance conducting inclusive research in this field. The recent Equipping Inclusion Studies *(Layton, Wilson, Colgan, Moodie and Carter 2010)* included a number of individuals living with post-polio. Natasha previously worked with the Independent Living Centre and she took participants on a tour of the ILC to demonstrate AT that works for polio survivors.

**Mary-ann Liethof, National Program Manager, Polio Australia**
Mary-ann has worked with the post-polio community since 2004 and currently facilitates annual Polio Health & Wellness Retreats for up to 70 polio survivors and their family member/carers in various states. She provided an overview of the role of Polio Australia, including support services available.

At the end of the workshop, participants were asked to complete an evaluation form. A summary of the responses follow: Professions represented were nearly half each physiotherapists and occupational therapists, with one nurse and a couple of case managers; The overwhelming response was positive to Polio Australia's first PPS/LEoP training workshop, with all attendees saying they would recommend the session to other treating health professionals (THPs); Around 75% showed interest in being recognised as an informed/experienced LEoP and/or PPS practitioner; Virtually all attendees said that THPs need information on PPS/LEoP, and most said they would take follow-up action; All attendees said they could now better understand and recognise LEoP/PPS symptoms; Most participants said the session helped them to understand how LEoP/PPS exercise differed from neuro/ageing clients and provided polio management options; Three quarters of attendees said they now have better awareness of how Polio Australia supports polios/THPs.

***Polio Australia is very encouraged by the level of interest and positive feedback provided by these health professionals. With adequate funding, training workshops like this could be promoted and delivered across Australia to ensure appropriate health services are provided for the thousands of polio survivors needing treatment and support.***

## In Case of Emergency *(cont'd from p1)*

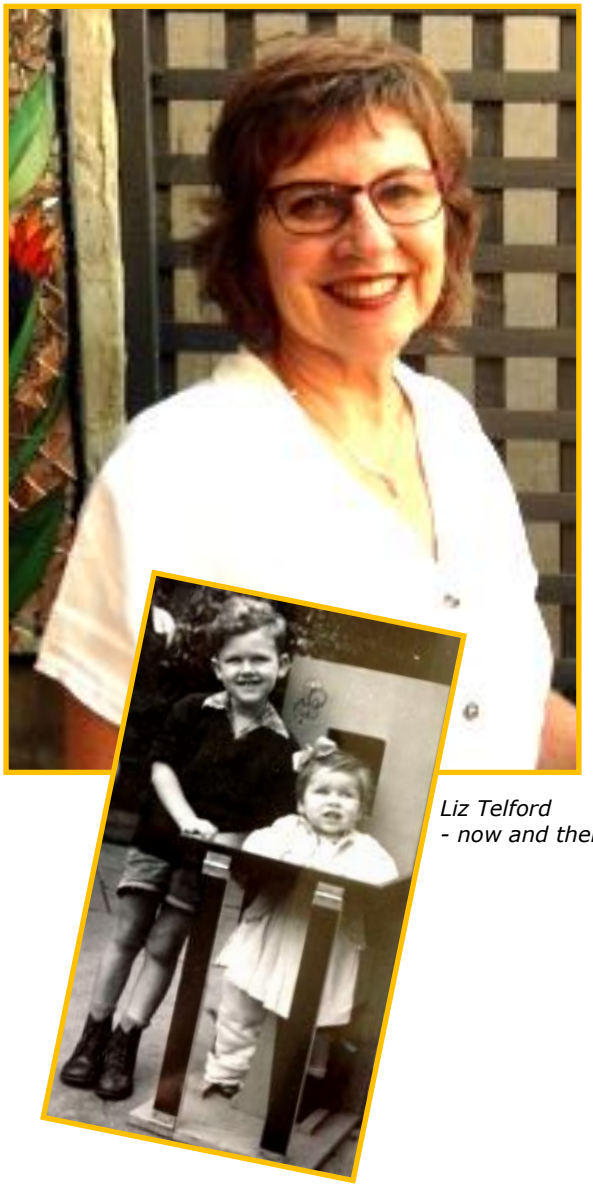
I needed a good relationship with this person and the surgeon on the other side of the door.

After my husband said for a second time that we are advised to provide this information and we would find it reassuring if she would just look at it, she reluctantly agreed to glance at a second document we proffered ("*Summary of Anesthesia issues for the post polio patient*" by Selma H. Calmes, MD, Chairman and Professor (retired), Department of Anesthesiology, Olive View-UCLA Medical Center, Sylmar, California) but dismissed the information as irrelevant in this case. However, she did agree to send me for recovery in Intensive Care for extra monitoring.
Following the surgery, I recovered well for the first few hours but then my condition deteriorated and I remained in the Intensive Care Unit longer than expected. I wanted to know why I felt so unwell. Could this be due to any post polio effects, I asked. I may be more sensitive to anesthesia drugs, to morphine and perhaps there are other central nervous system issues involved I explained. They did not know. I asked to have my blood gasses monitored, as I understood that this is best practice for post polio patients post operatively. More rolled eyes. I was aware that lying on my back, being administered oxygen and having difficulty coughing could be risk factors for raised carbon dioxide levels. This was not usual procedure and required some persuading. I was anxious to leave the ICU.

Had the staff read even the summary we gave of anesthesia issues they would have been alerted to the difficulty some post polio patients have post operatively and we could have discussed this. I don't know if that is what was happening in my case but it would have been a useful and reassuring conversation to be having at the time, as they seemed to have no other explanation for my post operative response. I was very ill, reliant on their care and in no position to be researching anything. The lack of knowledge of post polio, the lack of receptiveness to receiving information from either my husband or me and the lack of communication made this a more stressful experience than it needed to be.

There is evidence that post polio impacts on people who have had non paralytic as well as paralytic polio and the numbers of both are unknown but thought to be up to 400,000 in Australia, so the medical profession will be coming across this time and again.

We seem to be in a situation where we are told to give information but then this is not listened to. I think back to my conversations with Mrs Jocelyn Towns and the other physiotherapists who supported me through those years and I wonder what she would say to me now. She knew the limitations of the doctors but also the determination of the polio patients. I suspect she would suggest that we continue to carry the cards and brochures but that we should also keep encouraging and expecting hospitals to take responsibility and develop sufficient knowledge and a process for treating people who have had polio. Perhaps this will also encourage doctors to be more receptive to the information we do provide.



*Liz Telford - now and then*

## Polio Battle Sparked Robert Redford's Jonas Salk Film

**Robert Redford's childhood brush with polio inspired him to direct a movie about a building named after vaccine inventor Jonas Salk.**
Source: www.express.co.uk—12 February 2014

The Hollywood veteran has stepped behind the camera to take charge of a short 3D documentary which is part of a six-part series about iconic buildings called Cathedrals of Culture.

Redford's installment focuses on the Salk Institute for Biological Studies in San Diego, California, which was founded in 1960 by Jonas Salk, the scientist who developed the first polio vaccine, and Redford admits his own struggle with the disease, aged 11, inspired him to tackle the project.

He says, *"From a personal standpoint I knew something about the building because I grew up in Los Angeles not far from that area... so I was around when that building was being built. Also, I was around when the polio epidemic was still a threat. You could get it. I had a mild case of it myself when I was 11 years old, and fortunately it was mild enough not to cause me any real damage. Polio was part of the picture, so when Jonas Salk invented the vaccine, it was just earth-shattering news."*

## The Unusual Story of Tanaquil Le Clercq, Artist and Muse

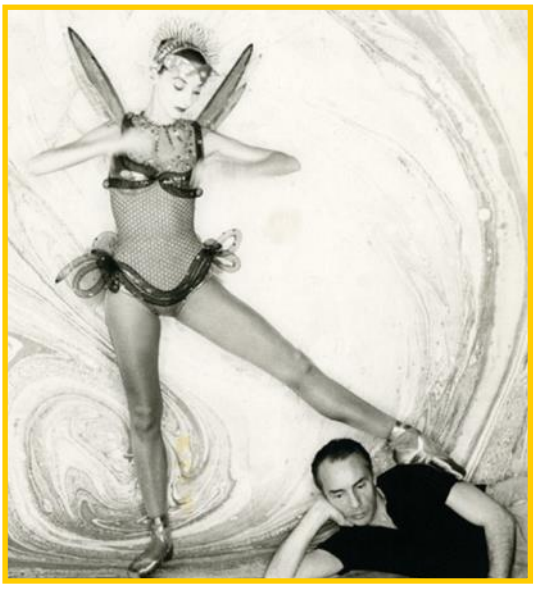
***by Stephen Holden***
Source: The New York Times - 4 February 2014

As you watch grainy kinescope footage of dancers in a mirrored studio executing a pas de deux in the documentary biography *"Afternoon of a Faun: Tanaquil Le Clercq"*, it is almost as though you are beholding mythological deities who have alighted briefly on the earth. Here today, gone tomorrow, they are like rare birds, seldom glimpsed, who remind us of the evanescence of all things, most of all physical beauty and the casual grace of youth. Therein lies a primal attraction of ballet: its evocation of the ecstatic moment is as fleeting as it is haunting.

In this sequence, which opens and closes this film by Nancy Buirski, Le Clercq and her noble, bare-chested partner Jacques d'Amboise dance to the Debussy tone poem *"Prelude to the Afternoon of a Faun"*, as choreographed by Jerome Robbins. Because Le Clercq, one of the great ballerinas of the 20th century and a muse to Robbins and George Balanchine, was struck by polio at 27, that foreknowledge lends this sequence and another from *"La Valse,"* which ends in a ballerina's death, a tragically prophetic resonance.

When Le Clercq was 15 and one of the brightest lights at Balanchine's School of American Ballet, she danced the role of a girl with polio in his *"Resurgence"*, commissioned for a March of Dimes benefit. Wearing a black cape, Balanchine himself played the Threat of Polio. Many years later, he worried that somehow he had brought on the disease.

Le Clercq became ill during the 1956 European tour of New York City Ballet, Balanchine's company. Although most of the dancers had been given the polio vaccine before the trip, Le Clercq decided at the last minute to wait. She collapsed while in Copenhagen, was confined to an iron lung and spent several months in a Danish hospital. She never walked or danced again. Balanchine did everything in his power to help restore her agility, to no avail.



Read full article here.

## Extra Weight May Add to Elderly Fall Risk

### I went to where the grownups go

*by Peter Willcocks Jan 2014*

I went to where the grownups go today.
and no one held my hand.
I was quite in charge
and it wasn't at all scary.

It was just like it used to be.
No one to tell me where to go
or to watch out for this and that.

I never heard that question once
Are you alright?
Are you sure?
Do you need to rest?
Please sit down, for a while
I'll find you a seat.

Well,
I went out to where the grownups go, today,
to a market full of clothes, food, cobble stones and smelly stuff.
Lots of things to trip over and bash into,
I went right into the crush of things.
I had so much fun
dodging between
and around.

I felt just like a
grownup today,
an independent one,
in my new
power
wheel
chair.

***by Shereen Jegtvig***
19 February 2014
Source: Australian and New Zealand Journal of Public Health 2014

NEW YORK (Reuters Health) - For Australians over age 65 included in a new study, being obese raised the risk of experiencing a fall by 31%.

*"Falls are one of the most common causes of injury for older individuals and as the world population ages, the number of fall-related injuries are projected to increase rapidly,"* said lead author Rebecca Mitchell.

*"Likewise, rates of overweight and obesity among older individuals are also increasing,"* added Mitchell, a researcher with Neuroscience Research Australia at the University of New South Wales.

Mitchell and her colleagues wanted to determine whether overweight and obesity added to the risk of falling among older adults, as well as the risk of being injured in a fall.

The researchers used information from the New South Wales Prevention Baseline Survey, a large Australian population study started in 2009.

A total of 5,681 people 65 years of age and older were asked about their history of falling, their perception of their own risk of falling, their general health status, medication use and activity levels.

Participants who had fallen one or more times in the previous 12 months as a result of accidentally losing their balance, tripping or slipping were also asked how many of those falls resulted in injury and how many required medical attention or led to hospital admission.

According to the results published in the Australian and New Zealand Journal of Public Health, 23% of healthy-weight respondents had fallen once during the previous 12 months and 34% had fallen more than once.

About 30% of obese respondents fell once and another 45% fell more than once, making the overall fall risk 31% higher in the obese group.

The obese participants who fell didn't have any higher risk of fall-related injuries compared to healthy-weight people who fell, but they were more likely to have other health conditions - such as heart disease, diabetes and high blood pressure - and to report being in moderate or extreme discomfort.

Those who were obese and fell were also more likely to be taking four or more prescription medications.

"*It is difficult to know for certain why the risk of falling*

***Cont'd P 13***

## Extra Weight May Add to Elderly Fall Risk (cont'd from p12)

*increases for obese individuals, but it is likely to be as a result of reduced peripheral sensation, general physical weakness and instability when standing or walking,"* Mitchell said.

There are a number of common risk factors that can increase any older person's risk of falling, she added.

*"These can include individual factors such as: poor health, instability when standing or walking, some health conditions, such as poor vision or dementia, lack of physical activity, use of multiple medications that can affect balance, and a poor diet,"* Mitchell said.

Risks can also be in an older person's environment, including *"uneven or slippery floors, unsecured floor coverings, such as rugs, inappropriate footwear or eyewear, or inadequate lighting,"* she said.

*"As to why fall-related injuries do not increase for obese individuals this is likely to be as a result of adipose tissue (fat) protecting bone,"* Mitchell said.

Compared to the healthy-weight group, the obese participants in the study were more likely to be sedentary for eight or more hours a day, to walk less, to have problems walking and to believe that nothing could be done to prevent falls.

Mitchell and her colleagues point out that obesity is associated with a higher risk of certain chronic illnesses, but also that chronic conditions such as lung disease and arthritis can limit activity, leading to weight gain.

To reduce the risk of falls among obese older people, tailored activity programs, such as strength and balance training, as well as home safety assessments and eyesight checks could all be of benefit, they write.

*"Everybody knows how falls can be life-changers for older people, from breaking a hip to hitting your head, so if we can prevent them that's always better and there's a lot that can be done,"* Dr Sharon Brangman told Reuters Health.

Brangman, who is Chief of Geriatrics at SUNY Upstate University Hospital in Syracuse, New York, and a past president of the American Geriatric Society (AGS), was not involved in the new study.

*"We know that when people fall, the biggest problem afterwards is a fear of falling because then they move less or when they walk they hold themselves really rigid and tight which actually increases the risk for falling,"* Brangman said.

The American Geriatric Society published fall prevention guidelines for physicians in 2012, she noted. Though they are intended for doctors, some of the suggestions may help families assess the risk in their homes (see: http://bit.ly/1cWjB86).

According to the U.S. Centers for Disease Control and Prevention, about one of every three Americans over age 65 suffers a fall, and every year 2 million of those falls result in emergency room visits.

The AGS guidelines were intended to encourage healthcare providers to ask about falls, according to Brangman, *"because a lot of times it's not asked and patients don't volunteer it because they don't want anyone to know. They're so afraid that will mean they need to be placed in long-term care or something."*

Brangman said that sometimes patients who are overweight might need a little extra support to realize that their situation isn't hopeless and that there are things they can do, such as starting an exercise program.

Strengthening the quadriceps muscle group is especially recommended. *"Exercise programs that are tailored to the individual can make a difference, and it's really never too late to start doing something,"* Brangman said. *"Balance and strengthening exercises, especially exercises that strengthen the quads, are very important in preventing falls in the future."*

# Commonwealth Home And Community Care (HACC)

Source: The Department of Health

Did you know that the Commonwealth HACC Program provides services that support older people to stay at home and be more independent in the community?

The Commonwealth HACC Program provides 19 basic maintenance, support and care services to assist people to remain in the community.

The services focus on supporting different areas of need that an individual may have due to a limitation in their ability to undertake tasks of daily living and include:

- nursing care
- allied health services like podiatry, physiotherapy and speech pathology
- domestic assistance, including help with cleaning, washing and shopping
- personal care, such as help with bathing, dressing, grooming and eating
- social support
- home maintenance
- home modifications
- assistance with food preparation in the home
- delivery of meals
- transport
- assessment, client care coordination and case management
- counselling, information and advocacy services
- centre-based day care
- support for carers including respite services

## Who can access Commonwealth HACC services?

Commonwealth HACC services are available to people:

- aged 65 years and over (or 50 and over for Aboriginal and Torres Strait Islander people),
- in all states and territories *(except Victoria and Western Australia - see additional information below)*,
- who are at risk of premature or inappropriate admission to long term residential care, and
- carers of older Australians eligible for services under the Commonwealth HACC Program.

The Commonwealth HACC Program arrangements do not apply to Victoria and Western Australia, where HACC services continue to be delivered as a jointly funded Commonwealth-State program which provides services to older people and younger people with disabilities. The Australian Government and the Victorian and Western Australian State Governments maintain bilateral agreements for that purpose.

More detailed information is available on the **Commonwealth HACC services webpage** or to find out about services in your area phone 1800 200 422.

Contact details for information about HACC services in Victoria and Western Australia are as follows:

### Victoria

**Department of Health Victoria Switchboard**
Telephone: 1300 253 942
Email: Enquiries (enquiries@health.vic.gov.au)

### Western Australia

**Home and Community Care in Western Australia**
Telephone: (08) 9222 4222
Email: HACC WA (haccwa@health.wa.gov.au)

## Increased Payments for Carers

From 1 January 2014 the rate of payment for those who receive a Carer Allowance increased by $2.80 a fortnight - in line with the CPI - lifting the basic rate of payment to $118.20 a fortnight *(see table on page 15)*.

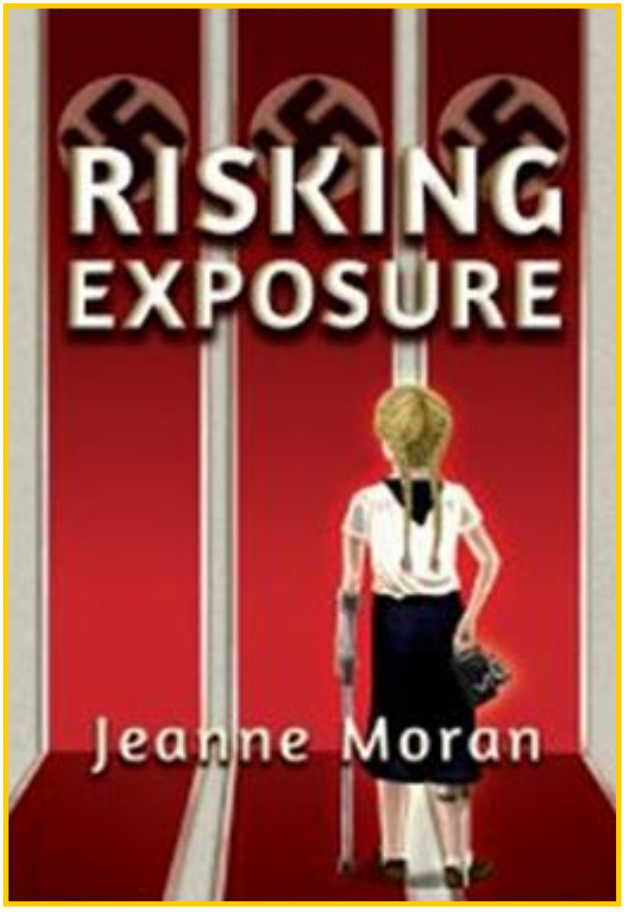
If you are a polio survivor, or live with/care for someone who is, and are not currently receiving any Benefits or Payments, check your eligibility here.

## HACC *(cont'd)*

| Miscellaneous Rates and Other Amounts | | | | |
|---|---|---|---|---|
| **Pharmaceutical Allowance** | | | | |
| **Family Situation** | **Previous Amount** | **1 Jan 2014** | **Increase** | |
| Single | $6.20 | $6.20 | $0.00 | pf |
| Couple | $3.10 | $3.10 | $0.00 | pf |
| Illness Separated | $6.20 | $6.20 | $0.00 | pf |
| **Carer Allowance - Rate** | | | | |
| | **Previous Amount** | **1 Jan 2014** | **Increase** | |
| Carer Allowance | $115.40 | $118.20 | $2.80 | pf |
| **Carer Payment - Care Receivers Income and Asset Limits** | | | | |
| | **Previous Amount** | **1 Jan 2014** | **Increase** | |
| Income limit | $101,656 | $104,096 | $2,440 | pa |
| Lower asset limit | $627,000 | $642,000 | $15,000 | |
| Higher asset limit | $931,750 | $954,000 | $22,250 | |
| **Mobility Allowance** | | | | |
| | **Previous Amount** | **1 Jan 2014** | **Increase** | |
| Standard Rate - single or couple | $87.00 | $89.10 | $2.10 | pf |
| Increased Rate - single or couple | $121.80 | $124.70 | $2.90 | pf |

*Source: Department of Social Security*

## Risking Exposure by Jeanne Moran




Munich, 1938. Nazi Germany. War is on the horizon. The law makes fourteen-year old Sophie Adler a member of Hitler Youth; her talent makes her an amateur photographer.

Then she contracts polio. During her long hospitalization, her Youth leader supplies her with film. Photographs she takes of fellow polio patients are turned into propaganda, mocking people with disabilities. Sophie is now an outsider, a target of Nazi scorn and possible persecution. Her only weapon is her camera.

Will she find the courage to separate from the crowd, photograph the full truth, and risk exposure?

Purchase online at Amazon.

# Elderly Patients: Making Wise Choices

***by Laurie Scudder, DNP, NP,***
***Paul L. Mulhausen, MD, MHS***
Source: Medscape – 27 February 2014

*The Choosing Wisely® initiative of the American Board of Internal Medicine (ABIM) Foundation was launched in 2012 with a goal of reducing overuse of tests and procedures, and helping patients, in consultation with physicians, to make smart and effective care choices. Since then, 30 professional societies have joined the effort, releasing lists of common practices that should be questioned by both healthcare professionals and patients.*

*This month, the American Geriatrics Society (AGS) released their second "Top 5" list of low-value practices in the care of older adults. Medscape spoke with Paul Mulhausen, MD, MHS, Chief Medical Officer at Telligen and Chair of the AGS Choosing Wisely workgroup, about the recommendations and key take-home messages for clinicians.*

**Recommendation 4:** Don't prescribe a medication without conducting a drug regimen review.

**The rationale:** Older patients use more prescription and nonprescription drugs than other populations. This increase in medication burden - particularly concerning when high-risk and potentially additive medications are used - may lead to diminished adherence; adverse drug reactions; and increased risk for cognitive impairment, falls, and functional decline. Medication review identifies high-risk medications, drug interactions, and those continued beyond their indication.

**Medscape: This recommendation is really a mouthful! The risks of polypharmacy are well documented, but clear strategies for deprescribing are lacking. What do you recommend as best practice for both reviewing medication and possibly discontinuing those that are no longer appropriate?**

**Dr. Mulhausen:** There are several issues here. If you work in the domain of geriatric care or immerse yourself in the geriatric literature, you become very aware of the unintended adverse consequences of treatment. Older people who are losing homeostatic reserve become more vulnerable to the adverse effects of medical intervention. We (as geriatricians, and all of those who treat older adults) think a lot about side effects of medications; we think a lot about the safety of procedures, because our clientele is predictably more vulnerable to those problems.

All of the Choosing Wisely committee members had an interest in advising people to use less medication. There is clear evidence of undertreatment or overtreatment, and duplication in treatment, as well as a trend toward an increased risk for adverse effects from medical interventions.

The committee felt strongly that the standard of care should be that medications and other treatments are reconciled periodically, and those that are no longer necessary, have no indication, or are duplicated should be reviewed for discontinuation. How to identify that? The AGS Beers Criteria for potentially inappropriate medications provides a strategy to make sure that the treatment program is truly necessary and truly effective, and not duplicative.

The other part of that process is to look for undertreated indications. So you were right: This is a complex recommendation. It's rooted in our belief that treatment regimens can be both helpful and harmful and that we truly need to proactively manage the medication treatment regimens of the geriatric patient, because the payback for that proactive management is so much greater.

**Medscape: In your experience, are most clinicians familiar with the Beers criteria?**

**Dr. Mulhausen:** I do not think they are universally known, although they are widely used in the geriatric and long-term care communities, as a quality benchmark. Certainly, there are more people in the primary care disciplines who are probably aware of it, but I don't think it's the majority.

This is anecdotal, but in a presentation recently, I polled the audience of maybe 100 people to ask about their use of this document, and approximately 5 raised their hands to say they were familiar with the Beers criteria. I don't think they're broadly known.

Some clinicians feel that the Beers criteria overstate risk in identifying potentially inappropriate medications. I don't. I am very comfortable with the list and believe it has been developed and vetted in a rigorous process. I think there is continued value in promoting the

***Cont'd P 17***

## Elderly Patients: Making Wise Choices *(cont'd from p16)*

Beers list as a potentially helpful tool.

Other Recommendations:

**Recommendation 1:** Don't prescribe cholinesterase inhibitors for dementia without periodic assessment for perceived cognitive benefits and adverse gastrointestinal effects.

**The rationale:** Although some patients with mild-to-moderate and moderate-to-severe Alzheimer disease (AD) achieve modest benefits with use of cholinesterase inhibitors, including delayed cognitive and functional decline and decreased neuropsychiatric symptoms, the impact of these drugs on institutionalization, quality of life, and caregiver burden are less well established. Treatment plans must also include advanced care planning, patient and family education, diet and exercise, and other nonpharmacologic approaches.

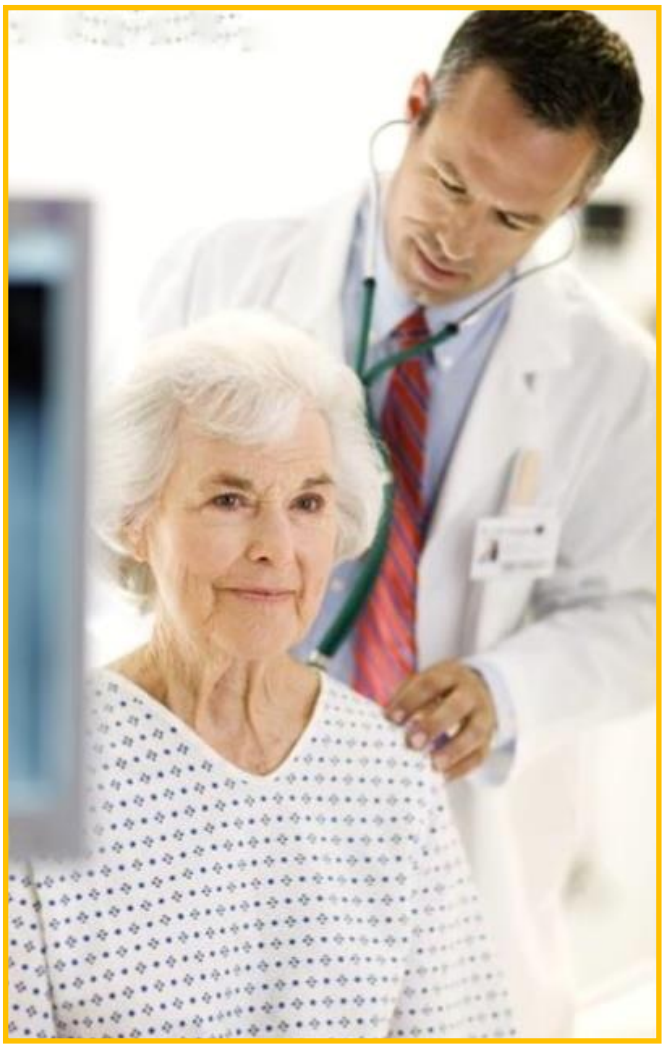
**Recommendation 2:** Don't recommend screening for breast or colorectal cancer, or prostate cancer (with the prostate-specific antigen [PSA] test), without considering life expectancy and the risks of testing, overdiagnosis, and overtreatment.

**The rationale:** Cancer screening is associated with a number of risks, including the risk for overdiagnosis and unnecessary treatment. The number needed to screen and treat in order to prevent a single death is over 1000 for both breast and prostate cancer in elderly adults.

**Medscape: This recommendation is not discouraging screening all older adults for breast, colorectal, or prostate cancer - but rather, only those with a life expectancy of less than 10 years.**

**Recommendation 3:** Avoid using prescription appetite stimulants or high-calorie supplements for treatment of anorexia or cachexia in older adults. Instead, optimize social supports, provide feeding assistance, and clarify patient goals and expectations.

**The rationale:** Although high-calorie supplements increase weight in older people, there is no evidence that they affect other important clinical outcomes, such as quality of life, mood, functional status, or survival. Stimulants such as megestrol acetate and cyproheptadine should be avoided in older adults, as noted in the 2012 AGS Beers criteria.



Studies of cannabinoids, dietary polyunsaturated fatty acids (DHA and EPA), thalidomide, and anabolic steroids have not demonstrated the efficacy or safety of these agents for weight gain in elderly adults.

**Recommendation 5:** Avoid physical restraints to manage behavioral symptoms of hospitalized older adults with delirium.

**The rationale:** Physical restraints can lead to serious injury or death and may worsen agitation and delirium. Effective alternatives include strategies to prevent and treat delirium, identification and management of conditions causing patient discomfort, environmental modifications to promote orientation and effective sleep/wake cycles, frequent family contact, and supportive interaction with staff. Physical restraints should only be used as a very last resort and should be discontinued at the earliest possible time.

## Lack of Vitamin D Linked to Inflammation

***by Marlene Busko***
Source: Medscape – 27 February 2014

COLERAINE, UK — Older, healthy individuals who were deficient in 25-hydroxy vitamin D (vitamin D) tended to have higher levels of biomarkers linked with cardiovascular disease (CVD) and inflammatory conditions such as multiple sclerosis and rheumatoid arthritis, in an observational study . More specifically, individuals who had a vitamin-D deficiency had significantly higher levels of interleukin-6 (IL-6) and C-reactive protein (CRP) and higher IL-6:IL-10 and CRP:IL-10 ratios, compared with their peers who were not deficient.

This is the first study to demonstrate that vitamin-D status is linked with markers of inflammation in a population of independently living, older adults and the first to investigate the link between vitamin D and inflammatory ratios, which may be more reliable measures of inflammation, **Dr Mary Ward** (University of Ulster, Coleraine, United Kingdom) advised in an email.

*"The results suggest that older adults with a deficiency in vitamin D may be at risk of having a more proinflammatory immune profile . . . which in itself may be a risk factor for [acute or] chronic disease development, [including] CVD, osteoporosis, and cognitive dysfunction,"* she said. *"However, further research needs to be undertaken in order to confirm these findings."*

*"I think all of us now think that inflammation is a critical factor in a lot of disease . . . so there's some rationale for thinking about trying to reduce chronic inflammation with something as simple as vitamin D, and it may have a further effect on atherosclerotic risk of cardiovascular disease,"* **Dr Clifford J Rosen** (Tufts University School of Medicine, Boston, MA), an author of the **Endocrine Society**'s scientific statement on nonskeletal effects of vitamin D, commented.

Strengths of the study by Ward and colleagues include that they looked at *"an older [population] with a good cross section of values for [vitamin D], and the deficiencies [were] really deficient; less than 25 nmol/L, which is less than 10 ng/mL, is really low, and those people [generally] have other comorbid conditions,"* Rosen added.

However, *"until we do randomized trials, these observational studies really don't provide us with much insight,"* he cautioned. The **Vitamin D and Omega-3 Trial** (VITAL), a randomized clinical trial of 20 000 men and women, which is looking at hard outcomes and expected to be completed in June 2016, should provide a clearer picture of the role for vitamin D and omega-3 supplements in preventing cancer and CVD, he noted.

The study was published online February 25, 2014 in the *Journal of Clinical Endocrinology and Metabolism.*

## Trials Unlikely to Support Vitamin D Supplementation

***by Marlene Busko***
Source: Medscape - 24 January 2014

A new meta-analysis of trials of vitamin D supplements for the prevention of myocardial infarction (MI), stroke, cancer, or hip fracture in seniors finds that, in general, taking vitamin D does not lower the incidence of these outcomes. Moreover, in a sequential meta-analysis, the researchers showed that any future clinical trials would also likely find that vitamin D supplements would not reduce the incidence of these outcomes by 15% or more.

It was unclear whether taking vitamin D supplements with or without calcium might reduce the risk for death by 5%, however.

*"The take-away message is that there is little justification currently for prescribing vitamin D to prevent heart attack, stroke, cancer, or fractures in otherwise-healthy people living in the community,"* lead author Mark Bolland, PhD, from the University of Auckland, New Zealand, told *Medscape Medical News* in an email.

*"In our paper, the only benefit from vitamin D was in reducing hip-fracture risk in elderly women living in residential care; in those 2 studies, the vitamin D supplements were given with calcium, at a dose of 800 IU/day, and higher doses are probably not necessary. In terms of harm, there was uncertainty as to whether vitamin D without calcium might increase the risk of hip fracture,"* he noted.

***Cont'd P 19***

## Vitamin D Supplementation (cont'd from p18)

One possible exception is people who truly have very low levels of vitamin D, who may benefit from supplements, he said. "*For people at risk of osteomalacia because of very low vitamin D levels — frail elderly people living in residential care, people who actively avoid the sun, and people with deeply pigmented skin — it is worth considering taking vitamin D supplements.*" However, "*For other people, vitamin D supplements are unnecessary,*" he stressed.

The study was published online January 24 in *Lancet Diabetes & Endocrinology.* In an accompanying editorial, Karl Michaëlsson, MD, from Uppsala University, Sweden, says the finding by Dr Bolland and colleagues that future studies are not likely to change the recommendation that most people will not benefit from vitamin D supplements is "*of particular interest.*"

**Do Vitamin-D Supplements Help, Harm, or Have Null Effects?**

A deficiency in vitamin D has been linked to fractures, ischemic heart disease, cerebrovascular disease, and cancer, yet taking vitamin D supplements remains controversial, "*probably because the evidence from randomized clinical trials has been fairly weak,*" Dr Bolland surmised. "*A few trials have showed positive effects of vitamin D supplements on various outcomes, but most show no effect, and a few have shown increased risk of fracture.*"

In the new paper, the researchers examined meta-analyses of studies looking at vitamin D supplements and MI, stroke, cancer, fractures, and mortality. Then they did a sequential analysis to see whether the risk estimates would be altered by future trials. They obtained data from 44 reports of 40 individual randomized controlled trials. The vitamin D doses in the supplements ranged from 200 to 1100 IU/day, or 100,000 to 150,000 IU every 3 months.

In 23 of the 32 trials (73%) that reported baseline 25-hydroxyvitamin-D levels, the average baseline level was less than 50 nmol/L, "*which is widely considered to be normal, although some people think higher levels, eg, from higher than 75 to 80 nmol/L, are normal,*" Dr Bolland explained. In most studies, among participants who took the supplements, 25-hydroxyvitamin-D levels increased to normal levels. The study participants were typically women in their 70s or 80s, and most trials lasted longer than a year.

"*The findings [of no benefit] will probably come as no surprise to people who have held skeptical views about the effectiveness of vitamin D supplementation,*" Dr Bolland speculated. "*On the other hand, people who have endorsed calls for widespread vitamin D supplementation will probably view these results as surprising.*"

In a review published in the *Lancet* by the same New Zealand research group last October (*Lancet.* 2014;383: 146-155), vitamin D supplements had no meaningful effect on bone density, "*and this taken together with the current findings that vitamin D supplements do not prevent fracture suggests that they don't have a role in preventing osteoporosis,*" Dr Bolland added.

**Use Supplements for True Insufficiency**

In his accompanying editorial, Dr Michaëlsson says a massive demand now exists for the measurement of blood concentrations of 25-hydroxyvitamin D, and supplemental use of vitamin D in the past decade has soared. For example, in the United States during the period from 2002 to 2011, sales of vitamin D supplements increased more than 10-fold, from $42 million to $605 million.

But he cautions that while several researchers have claimed that higher doses of vitamin D are needed to have a positive effect on health, high annual doses of vitamin D increase the risk for fractures and falls. "*Without stringent indications — ie, supplementing those without true insufficiency — there is a legitimate fear that vitamin D supplementation might actually cause net harm.*"

The finding by Dr Bolland and team that the "*the body of evidence is already sufficiently large*" so that future trials will not change the conclusion that vitamin D is not of use in most people is the most pertinent, Dr Michaëlsson stresses.

For his part, Dr Bolland concludes, "*Until more information is available, it would be prudent to choose a cautious approach to vitamin D supplementation and to put more emphasis on the development of evidence-based cutoff points for vitamin D inadequacy.*"

*The study was funded by the Health Research Council of New Zealand. The authors have reported no relevant financial relationships.*

*Lancet Diabetes Endocrinol* 2014. Published online January 24, 2014. Abstract Editorial

## Good News For Coffee Drinkers

### Coffee Consumption, the Metabolic Syndrome and Non-alcoholic Fatty Liver Disease

***by Yesil A, Yilmaz Y***

Source: Medscape - 6 January 2014

Coffee consumption is a part of daily life in most areas of the world. As such, a number of studies have evaluated the chemical composition and related effects that this enjoyable beverage may have on health and disease.

For many years, healthcare providers have advised patients to avoid excessive consumption because of a concern about caffeine dependence. Several recent studies, however, suggest that regular coffee consumption may modulate the risk for fibrosis in chronic liver disease.

Yesil and Yilmaz analyzed the experimental, epidemiologic, and clinical studies and the modulation of the metabolic syndrome and nonalcoholic fatty liver disease (NAFLD). Animal studies showed a reduction in the metabolic syndrome with improvements in glycemic and lipid regulation, as well as reductions in transaminases and proinflammatory cytokine hepatic gene expression. Other studies showed reductions in hepatic fat and collagen proinflammatory tumor necrosis factor, as well as

increases in anti-inflammatory interleukins. Epidemiologic and clinical studies demonstrated a significant inverse association between coffee consumption and prevalence of metabolic syndrome, as well as a reduced risk for NAFLD.

The meta-analysis by Bravi and colleagues is a logical extension of the data demonstrating the beneficial effects of coffee on NAFLD, now showing a reduction in associated risk for hepatocellular carcinoma (HCC). Sixteen studies were identified. Overall, compared with no coffee consumption, the risk for HCC was reduced by 28% with low-level consumption, and by 36% with high-level consumption (3 or more cups/ day). It is likely that this favorable effect is the result of reduced cirrhosis evident in coffee drinkers, as well as improvement in the metabolic syndrome, because diabetes is another known risk factor for HCC. The researchers adjusted for other major risk factors for HCC, including hepatitis B virus, hepatitis C virus, cirrhosis, alcohol use, and tobacco use.

*Aliment Pharmacol Ther.* 2013;38:1038-1044

## The Daily Living Expo

In 2014, ATSA will hold a Daily Living Expo at the Melbourne Showgrounds on Wednesday 14 May and Thursday 15 May, from 9am-4pm. There is plenty of parking onsite and easy access via public transport.


The exhibition will have over 100 exhibitors displaying a wide range of products and services for people with disability and the elderly. On display will be the latest in assistive technology, mobility solutions, pressure care, employment support, accessible recreation/holiday ideas, modified motor vehicles and a lot more.

A key feature of the Expo is the FREE Clinical Education Program – run over 2 days in rooms conveniently located next to the exhibition floor. The three track seminar program has over 20 speakers.

Admission is free to therapists, the general public, end users and ATSA members for both events.

# Is Polio-like Symptoms Cause For Alarm?

***by Dina Fine Maron***
Source: Scientific America – 25 February 2014 |

**A U.S. Centers for Disease Control and Prevention expert sheds light on five cases of children infected with an unidentified virus**

Just sixty years ago polio was one of the most dreaded childhood diseases in the U.S. Vaccination campaigns effectively stamped out domestic cases of the disease, with the last cases of naturally occurring paralytic polio in the U.S. in 1979. But news that a small number of children have developed polio-like symptoms in California has fueled instant public interest and concern. Keith Van Haren, a pediatric neurologist at Stanford University, said in a report released February 23 that five children between August 2012 and July 2013 had developed paralysis reminiscent of polio.

The children had previously been vaccinated against polio virus. And although the children were afflicted with paralysis and severe weakness, physicians have concluded the children do not have polio. Still, none of the children fully recovered limb function after six months. The jury is still out on exactly what caused their condition. Van Haren's findings will be presented at the American Academy of Neurology's annual conference in April. Physicians and public health officials have submitted 20 reports to the California Department of Public Health of similar cases. Thus far, the CDPH has not identified any common causes that suggest the cases are linked.

Polio virus is part of a larger family of enteroviruses, and the different types each carry a small degree of paralysis risk. Two of the children did test positive for one type of rare enterovirus, enterovirus 68. More common enteroviruses, however, are associated with respiratory conditions including pneumonia. Scientific American spoke with CDC's Deputy Director of the Division of Viral Diseases Jane Seward to get further insights.

[*An abridged transcript of the interview follows.*]
**These children did not test positive for polio, but two of the children did test positive for a different kind of enterovirus, enterovirus 68. What's your theory for what's going on here?**

Acute flaccid paralysis, that's acute paralysis of parts of the body–in this case the limbs, can result from a variety of viruses including polio virus and non-polio enteroviruses including enterovirus 68, West Nile Disease, echovirus and adenoviruses. Most people who get enteroviruses have mild symptoms and no testing is ever done on them. I think we're looking at a rare outcome in these children.

**Are we seeing these symptoms in places other than California?**
Acute flaccid paralysis is not a nationally notifiable disease in this country so we're really not able to assess the significance of this number of cases. Our understanding is that what happened here is these cases came from people that came in at first for testing of polio virus, or at least some of them did. That's great. We don't want physicians to forget about polio virus and they need to keep testing for it and be alert for it because polio could come from parts of the world where polio is endemic.

In countries that are performing regular surveillance there is at least one case of acute flaccid paralysis per year for every 100,000 people under 15 years old. We don't have that same system in place here but if we did the same numbers would apply. We would expect at least 80 cases of acute flaccid paralysis - at least - from California since they have a population of children under 15 of eight million. So, again, if we were conducting surveillance for acute flaccid paralysis we would expect at least 80 cases.

**So then are you saying this is expected or we should not be concerned?**
These researchers only report on five cases in the abstract, two of which tested positive for enterovirus 68. Based on that we are not unduly alarmed. We are in touch with California but not have been in touch with the researchers at Stanford that put the abstract together.

**Have there been other cases where enterovirus 68 causes paralysis?**
CDC tracks enteroviruses that circulate around the country using a passive reporting system from labs that happen to test for those viruses. That gives us no idea about the total numbers. It just tells us which viruses are circulating from year to year. We have had at least one reported case [of paralysis] as you can see in a *Morbidity and Mortality Weekly Report* from 2006. This is just the absolute tip of the iceberg of what may

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## Is Polio-like Symptoms Cause For Alarm? (cont'd from p21

be occurring around the country though, because the reports don't reflect the total numbers in the country. We don't have total surveillance. We are aware of 47 cases of enterovirus 68 since 2000. Those are just the ones we know have been isolated in laboratories and most were respiratory disease.

**Other than polio, would enterovirus 68 or any other enteroviruses be more likely to cause paralysis?**
No, they are not commonly known to cause paralysis. The most important thing to know is that enteroviruses are common and most people don't get very sick from them. It's only rare that these cause severe illness. With any case of paralysis a clinician should consider if it's polio virus and request testing for that.

**So what would spark an enterovirus to cause paralysis when that's such a rare symptom?**
It's probably a combination of how the host interacts with the virus. If you think about a condition like chicken pox it used to infect basically every single child in the U.S. With four million cases a year a hundred kids died. Why did those kids die? It's really hard to explain. It's an interaction of the virus and the host. Either genetically they didn't cope with the virus as well or they got an unusually high dose of the virus, it's hard to say.

**How do we test for enteroviruses to identify them?**
It's usually on the stool or through cerebral spinal fluid testing. It's better to get it out of the CSF because these viruses are common so if you pick up the virus from a nonsterile site like the throat or stool that may not tell you the child has it since healthy carriers could still shed the virus.

**How are enteroviruses other than polio transmitted? Is this an issue where you spread the virus through poor hygiene after interacting with feces?**
Definitely a lot of them are transmitted via respiratory secretions, especially this one– enterovirus 68, which is commonly associated with respiratory disease.

**So what can people do to protect themselves from this unidentified illness?**
The best way to protect yourself is if you have any respiratory symptoms to practice cough etiquette and cover your cough, or your sneeze. You should wash your hands often and stay home if you're sick.

# India Celebrates

## India celebrates polio success, but sad legacy remains

Source: The Economic Times - 10 January 2014

NEW DELHI: Teenage shoe-shiner Amit contracted polio as a toddler, leaving him with damaged legs and a twisted spine. He has never seen a doctor and the country's eradication of the disease came too late for him.

On Monday, India will mark three years since its last polio case, leaving it on the cusp of being declared free of the ancient scourge in what is arguably its, and one of the world's, biggest health success stories.

But the wretched sight of crippled street hawkers or beggars on trolleys, withered legs tucked underneath their bodies, will remain as a legacy of the infections that took hold during the country's time as an epicentre of the disease.

Amit, who uses only one name, was sent out to work aged nine to help clear his family's debt and has squatted on a pavement outside a busy restaurant serving south Indian food for the past five years.

He says he was about three or four when he found suddenly that he was unable to sit up straight on a family trip and he toppled off his mother's lap while travelling on a bus.

*"When we reached home, I still could not sit properly. Every time I would try to sit, I would keep tipping over and that's when my mother thought I've got polio,"* he told AFP in between serving customers.

*"My parents never took me to a doctor, they took me to a temple instead, offered prayers and sought blessings from a priest for a cure so that I could walk properly."*

The priest's prophecy that he would be cured of his problems by the age of 20 gave false hope. The contagious virus, once it attacks the nervous system, wreaks irreversible damage.

Estimates for the number of survivors left crippled in the country vary significantly.

In the absence of any official data, most experts agree it runs into several million given the history of the disease in India which affected up to 300,000 people each year before vaccinations began in the 1970s.

Even up to the mid-1990s, when eradication efforts began gaining momentum, 50,000-150,000 new cases were occurring annually, according to estimates from the World Health Organisation.

*"I am one of the happiest people that new cases are not being seen,"* said Mathew Varghese, one of India's leading polio surgeons who has been operating at New Delhi's St Stephen's hospital since 1987.

*"Today we don't have a single one - that is a huge achievement - but having said that there is also a backlog of cases which needs to be planned for,"* he said at his polio ward, one of the country's only such facilities.

*"These children who are stigmatised, hobbling or crawling or with crutches in their homes and villages, need to be brought to the mainstream."*

Rather than young children, many of the patients he now sees are in their teens or older, whose muscles have wasted away and joints have locked due to constant sitting.

*"They'll be here for another 30 or 40 years,"* he said. His operations involve inserting multiple pins into the affected legs, which are then put under gentle but constant tension to stretch out the muscles and bones until the limb is straight.

It is a long and painful process, requiring up to four months of hospitalisation and many more of physiotherapy, which St Stephens offers for free. At the end, the fortunate are able to walk, often with the use of callipers.

But as a result of shifting priorities, *"the new surgeons which are coming out have no skills in doing polio surgeries",* Varghese said.

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## India Celebrates *(cont'd from p23)*

Deepak Kapur from the Rotary charity, which funded the polio vaccination programme alongside the Indian government, UN children's agency UNICEF and the Gates Foundation, estimates there are three to four million Indians left crippled by the disease.

*"We would encourage people all across the country and all across the world to look after the polio survivors because it is not an easy job for them,"* he said. *"They all need the facilities to lead a dignified life."*

For understandable reasons, the focus of India's fight against polio has so far been on ending new cases, something for years thought impossible in a vast country with poor sanitation.

While it was stamped out in Western nations more than 30 years ago, the highly contagious virus which spreads through faecal matter broke out annually in India and was carried to other countries by migrants.

But after billions of dollars and private and public investment in a vaccination programme, January 13, 2011, marked the last reported case when an 18-month-old girl in a Kolkata slum was found to be infected.

India was taken off a list compiled by the World Health Organisation (WHO) of countries where polio is considered endemic, leaving just Pakistan, Afghanistan and Nigeria.

Now, three years since the last infection, India will be certified by the WHO as having eradicated the disease once all records are checked around the country.

This announcement is expected some time in February or March. For Amit though, the future holds more labour shining shoes on the tough streets of the capital.

*"I had thought about studying, but my parents had to pay off debts that came from temple visits, prayers, ceremonies and various offerings for my treatment,"* he said.

*"I don't like this work anymore. I used to like it initially, but now I don't like it so much. I want to learn how to read and write."*

## Travellers Require Vaccination

**Travellers to and from 7 polio-affected countries will require vaccination**
Source: NetIndian News Network - 3 March 2014

India has decided that, as a preventive measure to stop the polio virus from coming into the country, all travellers from and to seven polio-affected countries would be required to take the oral polio vaccine (OPV).

The seven countries are Afghanistan, Ethiopia, Syria, Kenya, Somalia, Nigeria and Pakistan.

All travellers coming from these countries to India would need to take OPV six weeks before departure from their country. Polio vaccine will also be administered to all travellers from India to these polio-affected countries.

The new polio vaccination regime has come into effect from 1st March, 2014, an official press release said.

India has not reported any case of polio for more than three years. In the next step, India, along with the remaining countries of the World Health Organisation's (WHO) South-East Asia region would be certified as polio-free.

However, the risk of polio persists as Afghanistan, Pakistan and Nigeria continue to be polio-endemic, re-infecting six countries in 2013 and causing major polio outbreaks in the Horn of Africa region and the Middle East.

Read full article here.

## Polio This Week

**Source:** [Polio Global Eradication Initiative](#) - as of Wednesday 5 March 2014

**Wild Poliovirus (WPV) Cases**

| Total cases | Year-to-date 2014 | Year-to-date 2013 | Total in 2013 |
|---|---|---|---|
| Globally | 28 | 9 | 406 |
| - in endemic countries | 28 | 9 | 160 |
| - in non-endemic countries | 0 | 0 | 246 |

**Case Breakdown by Country**

| Countries | Year-to-date 2014 | | | | Year-to-date 2013 | | | | Total in 2013 | Date of most recent case |
|---|---|---|---|---|---|---|---|---|---|---|
| | WPV1 | WPV3 | W1W3 | Total | WPV1 | WPV3 | W1W3 | Total | | |
| Pakistan | 24 | | | 24 | 5 | | | 5 | 93 | 14-Feb-14 |
| Afghanistan | 3 | | | 3 | 1 | | | 1 | 14 | 31-Jan-14 |
| Nigeria | 1 | | | 1 | 3 | | | 3 | 53 | 01-Feb-14 |
| Cameroon | | | | 0 | | | | 0 | 4 | 30-Oct-13 |
| Somalia | | | | 0 | | | | 0 | 194 | 20-Dec-13 |
| Syria | | | | 0 | | | | 0 | 25 | 17-Dec-13 |
| Ethiopia | | | | 0 | | | | 0 | 9 | 5-Nov-13 |
| Kenya | | | | 0 | | | | 0 | 14 | 14-Jul-13 |
| **Total** | **28** | **0** | **0** | **28** | **5** | **0** | | **9** | **406** | |
| **Total in endemic countries** | **28** | **0** | **0** | **28** | **5** | **0** | | **9** | **160** | |
| **Total out-break** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **246** | |

Data in WHO as of 05 March 2013 for 2013 data and 04 March 2014 for 2014 data.

On 27 February, the world's leading Islamic scholars, led by the Grand Imam of the Holy Mosque of Mecca, stated that protection against diseases is obligatory and admissible under Islamic Shariah, and that any actions which do not support these preventive measures and cause harm to humanity are un-Islamic. The scholars adopted a strong 'Jeddah Declaration' and a focused six-month Plan of Action to address critical challenges facing polio eradication efforts in the few remaining polio-endemic parts of the Islamic world: a ban on vaccinations and lack of access to children in some areas, deadly attacks on health workers, and misconceptions by communities about mass vaccination campaigns. More.