



AN ANTI-INFLAMMATORY DIET: IMPROVE YOUR CONDITION THROUGH GOOD EATS.1



GENDER DIFFERENCES: COPD GROWING FASTER IN WOMEN....5



COPD PEOPLE: KATHY CLARKE FORMER ROM EXHIBITION OFFICER PARTICIPATED IN AN ARCHAEOLOGICAL DIG.7

Living with COPD

Can an anti-inflammatory diet help?

While scientific research is limited regarding the benefits of the anti-inflammatory diet in COPD, available research suggests that following an anti-inflammatory diet may help reduce C-reactive protein, a substance in the body that is found in higher levels when infection is present. Moreover, there's at least some evidence that an anti-inflammatory diet may help reduce inflammation in long-term, inflammation-related illnesses such as diabetes, metabolic syndrome and obesity.

Inflammation on the surface of the body appears as local redness, heat, swelling and pain. It is the cornerstone of the body's healing response, bringing more nourishment and more immune activity to a site of injury or infection. But when inflammation persists or serves no purpose, it damages the body and causes illness. Stress, lack of exercise, genetic predisposition, and exposure to toxins (like secondhand tobacco smoke) can all contribute to such chronic inflammation, but dietary choices play a role as well. Learning how specific foods influence the inflammatory process is the best strategy for containing it and reducing long-term disease risks.

An anti-inflammatory diet is an eating plan designed to reduce chronic inflammation. While there is no strict rule on what constitutes an anti-inflammatory diet, nor is there much research on it as a treatment for chronic inflammation, the basic tenets of the diet are the same for any healthy eating plan—eating lots of veggies, fruits and healthy proteins and fats, while limiting the intake of highly processed foods. An anti-inflammatory diet is not a diet in the popular sense—it is not intended

Continued on Page 6

Chronic Obstructive Pulmonary Disease The complications of COPD

Traditionally, physicians have measured the severity of COPD by the amount of air that a person can forcibly exhale in one second (FEV1). The amount decreases as COPD gets worse. However, COPD affects other systems and body parts, which provide clues about the severity of the disease. Many physicians now use the BODE index to categorize COPD and predict its outcome. BODE stands for body-mass index, degree of airflow obstruction, dyspnea (breathlessness), and exercise capacity measured in a six-minute walk test.

The leading cause of death from COPD is respiratory failure. However, patients with mild-to-moderate cases also tend to develop cardiovascular disease or lung cancer. This likely occurs from inflammation, a main component of the condition.

Emphysema: If emphysema is detected before it causes symptoms, there may be some chance of reversing it. However, permanent changes in the alveoli usually occur even in young smokers. Patients with the inherited form of early-onset emphysema are at risk for early death, unless the disease is treated and its progression stopped or slowed. Emphysema patients who have significant, unplanned weight loss (a sign of muscle wasting) have a poorer outlook, regardless of lung function.

Chronic bronchitis: Chronic bronchitis does

Continued on Page 2

Ask Dr. Chapman

by Kenneth R. Chapman, MD, MSc, FRCPC, FACP

Director of the Asthma and Airway Centre of the University Health Network, Toronto



What is lung volume reduction surgery? How is it used for patients with COPD?

Lung volume reduction surgery (LVR) has become a treatment option for a small number of patients with very severe COPD. To understand how it works, it's important to recognize that tobacco smoking does not usually damage the lungs uniformly but damages the lungs in a patchwork fashion. Some areas of the lung are very badly damaged, some are moderately damaged and some are relatively normal.

Continued on Page 2

Ask Dr. Chapman

After careful planning and with the help of

Continued from Page 1 some detailed X-ray studies, the thoracic surgeon (lung surgeon) removes the most severely damaged portions of the lung leaving more room for the less damaged lung to work.

When it was first devised, LVR required large incisions between the ribs or through the breastbone to expose the lungs. More often now, thoracic surgery is undertaken as “keyhole” surgery using instruments inserted through small incisions and guided by fiberoptic scopes. By either method, a general anesthetic is required. Whether done traditionally with a scalpel or via fibre optics, removing portions of the lung in someone with severe COPD is considered major surgery.

How does removing damaged portions of the lung improve someone’s breathing?

The narrowed or obstructed breathing tubes in COPD tend to collapse or close as people breathe out. This traps excess air in the chest, a phenomenon that doctors call “hyperinflation”. The most badly damaged or obstructed portions of the lung in COPD become hyperinflated or distended, taking up space and preventing healthier parts of the lung from inflating and deflating normally. Removing the badly damaged lung quite literally gives the healthier lung more breathing space.

Does this mean everyone should consider LVR for their COPD?

Definitely not. Not everyone benefits. The intervention is considered only when someone is severely disabled by breathlessness despite having done all the right things—smoking cessation, several inhaled medicines and pulmonary rehabilitation. If there are no other big health problems and if the X-rays show a patchwork or uneven distribution of COPD, the option of LVR might be considered. The best candidates are patients whose most badly damaged lungs are in the upper lobes (the upper part of the chest). Someone considering the surgery must understand fully the risks involved.

Do people live longer after LVR?

It’s not clear that people live longer but in carefully selected patients there can be a significant decrease in breathlessness, an improvement in exercise tolerance and an improvement in quality of life. Some COPD experts consider LVR to be a “bridging procedure” that delays the need to consider the most dramatic form of lung surgery for COPD, lung transplantation. That is, LVR may delay the need for transplantation by several years.

Dr. Chapman is Director of the Asthma and Airway Centre of the University Health Network, President of the Canadian Network for Asthma Care and Director of the Canadian Registry for Alpha1 Antitrypsin Deficiency. A graduate of the University of Toronto and a former member of the faculty at Case Western Reserve University, he is now a Professor of Medicine at the University of Toronto.

We invite your questions. Please mail questions to: Ask Dr. Chapman, c/o COPD Canada, 555 Burnhamthorpe Road, Suite 306, Toronto, Ont. M9C 2Y3. Or you can e-mail questions to: AskDrChapman@gmail.com

Complications continued from Page 1 not cause as much lung damage as emphysema, although the airways become blocked by mucus plugs, and narrow due to inflammation.

Poor air exchange leads to low oxygen levels and high carbon dioxide levels. This poor gas exchange can lead to serious and life-threatening conditions, that include severe breathing difficulty.

Acute exacerbations: Acute exacerbations describe events that happen when the airways suddenly become blocked and symptoms get worse. These events are associated with inflammation in the airways and are generally triggered by an infection in the airway or throughout the body.

Other factors that can trigger serious lung events include:

- Certain medications
- Exposure to irritants in the air (air pollution)
- Seasonal changes (hot weather)

Acute exacerbations include the following symptoms:

- Increased phlegm
- Thicker and darker phlegm
- Shortness of breath (this is most common)

Some acute exacerbations get better on their own, but they are still the most common cause of hospitalization. Exacerbations often must be treated with different medications.

Frequent acute exacerbations of COPD cause lung function to deteriorate quickly. Patients never recover to the condition they were in before the last exacerbation. In COPD patients who are hospitalized, mortality rates are 11 per cent. Survivors of a first hospitalization have 50 per cent chance of returning to the hospital within six months.

Impact on quality of life: Nearly half of COPD patients report some limitations in daily activities. Breathing becomes hard work. More than half of the patients with COPD have difficulty sleeping (insomnia). Such impairment in quality of life can negatively affect mood.

Those with COPD are more likely to have anxiety, depression, or another psychiatric disorder than people in the general population. Women with COPD are more susceptible to psychological problems than men. Having anxiety can cause exacerbations to last twice as long as long as they would otherwise. Depression also increases the risk of death in both those with stable COPD and in those with uncontrolled disease. Having depression may prevent people with COPD from eating properly, exercising, taking their meds as prescribed, and getting the medical care they need. Low oxygen levels also can impair mental function and short-term-memory. Psychological therapy may be helpful for people with COPD.

Nutrition: People with COPD often lack good nutrition. Patients with chronic bronchitis tend to be obese. Emphysema patients tend to be underweight. Loss of weight and muscle mass is linked to a poor outcome in COPD. Good nutrition improves the ability to exercise, which in turn builds muscle strength and lung function. Obese patients with COPD who lose weight tend to sleep better.

Impact on cardiovascular system: Over time, COPD causes low levels of oxygen (hypoxia) and high levels of carbon dioxide

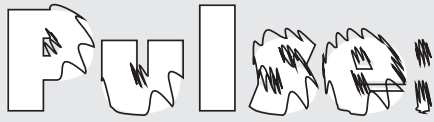
Continued on Page 6

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News about COPD

One in four Ontario hospital visits treats disease caused by smoking

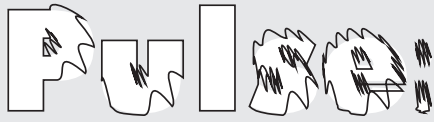
■ **Toronto** / Chronic obstructive pulmonary disease (COPD) is placing a huge burden on emergency rooms, an Ontario study has found. One quarter of all hospital visits in Ontario are made by patients with a condition linked to smoking, a new study has found. Ontarians who have chronic obstructive pulmonary disease (COPD), about 11 per cent of the population, account for one in four of all hospital and emergency room visits, according to the study, reported in the *Toronto Star*. The Toronto-based Institute for Clinical Evaluative Sciences found in smokers older than 35, COPD often is a terminal disease that only gets worse with age. In the short term, a person with COPD suffers from shortness of breath, wheezing and coughing. Respiriologist Andrea S. Gershon spent the last year poring over every single medical file belonging to the province's 853,438 COPD patients. Alongside her team of four other doctors, Gershon discovered that patients with the disease are clogging up hospital waiting rooms. "What we found is that it really has a huge burden on these emergency departments. They aren't just for COPD; they're for a lot of different things caused by COPD: shortness of breath, coughing up stuff, wheezing. They might be tired, have decreased exercise tolerance and sometimes they need oxygen," Gershon said. Gershon's study was the first of its kind because it analysed each and every COPD file in the province.

 <http://tinyurl.com/c38w9rw>

More evidence that smoking raises breast cancer risk

■ **Atlanta** / Cigarette smoking appears to increase the risk of breast cancer, especially when women start smoking early in life, new research indicates. For years, experts have questioned whether cigarette smoking is directly linked with breast cancer risk or whether the association is complicated by the fact that many women who smoke also drink alcohol, which has also been tied to breast cancer risk. Studies have produced conflicting results. When the U.S. Surgeon General last reviewed the issue in 2004, the report concluded that there was no cause-and-effect relationship between smoking and breast cancer risk. Now, however, researchers who took another look, analysing data from more than 73,000 women, have found strong evidence for a link between cigarette smoking and breast cancer. "It's not just a relationship between alcohol and breast cancer, but in fact smoking by itself is related to breast cancer," said Mia Gaudet, director of genetic epidemiology at the American Cancer Society. The timing of the smoking appears to affect the degree of risk, she said. "It seems that women who start smoking before their first birth are at greatest risk of breast cancer," Gaudet said. The researchers looked at data from women enrolled in a large, long-term cancer society study involving lifestyle factors and prevention. Over the follow-up of nearly 14 years, more than 3,700 cases of invasive breast cancer were found. The study finding, Gaudet said, "provides additional motivation for young women who are thinking of starting to smoke not to." Those who smoked while young and gave up the habit still had a higher risk of breast cancer, she said, than never smokers.

 <http://tinyurl.com/cdssnkb>



Researchers identify substance to stimulate growth of air sacs in the lungs

■ **Baltimore** / Researchers have identified a naturally occurring substance, known as a growth factor, which could help stimulate growth of the air sacs (alveoli) in the lungs. The scientists believe that their findings could lead to new treatments to regrow the alveoli, which are often damaged in people with chronic obstructive pulmonary disease. The study, published in the journal *PLOS Genetics*, investigated a growth factor called hepatocyte growth factor (HGF). They looked at the effects of the substance on mice with COPD. Half of the mice received HGF and the other half of the group received a fake treatment, called a placebo. The results showed that the mice receiving HGF had a 17 per cent improvement in the size of their alveoli, compared to those that received the placebo. The HGF also offered a protective effect, preventing any further damage or destruction to the alveoli. The researchers believe their study is an important demonstration that a growth factor can be used as an effective treatment for COPD. In a study of mice, researchers at Johns Hopkins have identified a new molecular pathway involved in the growth of tiny air sacs. The scientists say their experiments may lead to the first successful treatments to regrow the air sacs in people who suffer from diseases such as emphysema in which the air sacs have been destroyed by years of smoking. The work may also suggest new therapy for premature infants born before their lungs are fully developed. "One of the most daunting challenges we face as physicians is helping patients with chronic obstructive pulmonary disease, such as emphysema, who have lost alveoli that are so crucial for lung function," says Enid Neptune, MD, associate professor of pulmonary and critical care medicine at the Johns Hopkins University School of Medicine. "Once those tiny air sacs are destroyed, there are no effective treatments to bring them back."

 <http://tinyurl.com/ccq5lbg>

Lungs from heavy smokers OK for transplant

■ **Philadelphia** / Lungs of heavy smokers can be donated safely for use in adult double-lung transplants, but recipients need to know the source of the potential transplant, researchers say in a new study. Researchers from Temple University in Philadelphia found that lungs from carefully selected donors who smoked at least a pack a day for more than 20 years may be used in certain transplant situations without affecting recipients' survival rates or deaths from lung cancer. The study authors said the use of lungs donated by heavy smokers could help more patients get the life-saving double-lung transplant they need. "Our findings demonstrate that the current criteria for lung transplantation can potentially be revised to include donors with a heavy smoking history," Dr. Sharven Taghavi, from Temple University Hospital, said in a news release from the Society of Thoracic Surgeons. "This may help decrease the shortage of donor lungs and decrease waiting list mortality. For example, a surgeon may choose to transplant lungs from a healthy donor who has good lung function despite heavy smoking, or lungs may be accepted from a less-than-ideal donor for a very sick patient," Taghavi said.

 <http://www.nlm.nih.gov/medlineplus/healthnews.html>

Gender Differences in COPD

A study¹ published in the *International Journal of Clinical Practice* notes that the worldwide prevalence of chronic obstructive pulmonary disease (COPD) is growing faster in women than in men.

The greater prevalence of COPD and related mortality reported for men in earlier epidemiological studies may be due to under-diagnosis of women. In addition, factors such as prevalence of symptoms, triggering stimuli, response to treatment, susceptibility to smoking, frequency of exacerbations, impairment in quality of life response to oxygen therapy, presence of malnutrition, airway hyper-responsiveness and depression are more frequently seen diagnosis in women with COPD. Despite these differences, the current guidelines for the diagnosis and treatment of men or women with COPD are the same.

It appears that exploring gender differences in COPD is a topic worthy of consideration and one that shows promise to promote change in how women with COPD are diagnosed and treated. Historically, there existed a perception that COPD occurs more often in men than women. This observation was supported by statistics such as those in 1959, when the number of men compared to women who died from the disease was reportedly five to one. Then it was noted that mortality rates in women dying from the disease between 1968 and 1999 increased by 382 per cent, while in men, only 27 per cent.

As the death toll in women continued to rise, the year 2000 marked the first year that more women than men died from COPD. This trend is expected to continue and likely to grow, as the number of women smokers has also increased in recent years.

The main symptoms of COPD include dyspnea (breathlessness), chronic cough and sputum production. Current research suggests that the effects COPD has on women are far more detrimental than they are in men suggesting gender-related differences in COPD symptoms. Reportedly, women are more likely to experience more severe shortness of breath, anxiety and depression. Furthermore, women have more frequent exacerbations than do men, and are at greater risk of malnutrition.

Two studies suggest that physicians are more likely to give a COPD diagnosis to a male patient rather than a female, in spite of having similar symptoms. This implies that there may be a gender bias when it comes to making a COPD diagnosis. Moreover, women are also less likely to be offered a spirometry test or referred to a specialist. Once doctors receive abnormal spirometry results, however, this gender bias seems to disappear. This is why spirometry testing is so important for both men and women found to be at risk for COPD.

There is growing evidence to support that women are more likely to have a greater reduction in lung function at

comparable levels of smoking than men. This may be because women's lungs are generally smaller, possibly exposing them to a greater amount of tobacco smoke despite men smoking the same number of cigarettes.

Some explanations for women being more susceptible to the harmful effects of tobacco smoke include under-reporting of tobacco consumption among women and a genetic predisposition for lung damage from smoking that is gender-specific. Other possibilities relate to hormonal effects on lung development and size of the airways and differences in the way women metabolize cigarette smoke when compared to men.

Roughly 15 per cent of all people who are diagnosed with COPD have never smoked. Notably, out of this group, nearly 80 per cent are women, suggesting that women may be more vulnerable to risk factors associated with COPD that are not related to smoking.

Smoking cessation remains the single most important, cost-effective intervention for anyone with COPD, regardless of gender. But, women who are successful at quitting show an average increase in FEV1% predicted that is 2.5 times greater the improvement in men during the first year of quitting. Additionally, research suggests that women who quit smoking benefit more in terms of lung function than do men, but that men show greater symptom improvement.

A 2005 *CHEST* study found when one's body mass index (BMI) is lower than 21, COPD mortality increases. It also noted that women typically have a lower BMI than men. The study concluded that it's important to eat right and add calories to your diet if you have a lower than normal BMI.

The increase in prevalence in COPD among women has prompted much needed research that is ongoing and future-driven. Current COPD guidelines have yet to recommend different treatment options for men and women.

¹ Cote CG, Chapman KD: Diagnosis and treatment considerations for women with COPD. *Int J Clin Pract* 2009 Mar; 63(3):486-493. doi: 10.1111/j.1742-1241.2008.01987.x.

Before making medical decisions

Your physician should be consulted on all medical decisions. New procedures or drugs should not be started or stopped without such consultation. While we believe that our accumulated experience has value, and a unique perspective, you must accept it for what it is...the work of COPD patients. We vigorously encourage individuals with COPD to take an active part in the management of their disease. You can do this through education and by sharing information and thoughts with your primary care physician and respirologist. Medical decisions are based on complex medical principles and should be left to the medical practitioner who has been trained to diagnose and advise.

Anti-Inflammatory continued from Page 1 as a weight-loss program (although people can and do lose weight on it), nor is it an eating plan to stay on for a limited period of time. Rather, it is way of selecting and preparing foods based on scientific knowledge of how they can help your body maintain optimum health.

Along with influencing inflammation, this diet should provide steady energy and ample vitamins, minerals, essential fatty acids dietary fiber, and protective phytonutrients. Eat a rainbow of organic fruits and vegetables. Load your plate with plenty of raw and cooked vegetables from each colour group and don't forget about adding extra leafy greens. Choose two to four servings of fresh fruits and be sure to include antioxidant fruits such as strawberries and raspberries. Eat three servings a day of whole grains such as brown rice, millet, quinoa, amaranth, or buckwheat. Small amounts of rice noodles or soba are okay, but limit yourself.

Go for the wild side of seafood when available, including salmon, sardines, anchovies, herring, and (some) shellfish. Seafood that is either sustainably farmed or wild-caught is best. Additionally, smaller, cold-water fish contain the least amount of mercury and the highest amount of Omega-3 fatty acid, which is most desirable on an anti-inflammatory diet.

Pick plenty of plant-based proteins. Start with one to two servings of organic beans and legumes every day. Then add one serving of a soy-based protein like tofu or edemame.

When plant-based proteins don't quite cut it, choose up to two servings per week of eggs, sheep or goat milk products, and one serving of meats such as chicken, turkey or lamb. Select essential fatty acids in the form of purified fish or omega flax oils. Grab a handful of nuts or seeds, such as walnuts or almonds. Olive, walnut and sesame oils are great for cooking. Avoid oils that are genetically modified — like soy, corn, canola or other blended oils. They are purported to contribute to inflammation.

Keep hydrated; drink plenty of water and green tea—at least eight, eight-ounce glasses a day. Try small portions of healthy desserts such as dried, unsweetened, fruits, fruit sorbet, and even a few squares of dark chocolate (70 per cent cacao.)

Foods containing Omega-6 fatty acids should be eaten in moderation while on this diet as they increase the natural production of inflammatory chemicals in the body. Because there are some health benefits derived from Omega-6 fatty acids such as they help maintain bone health, regulate metabolism and promote brain function, they should not be cut out completely. Rather, balancing Omega-6 fatty acids with Omega-3 fatty acids is a recommended strategy.

The best way to obtain all of your daily vitamins, minerals, and micronutrients is by eating a diet high in fresh foods with an abundance of fruits and vegetables. In addition, supplement your diet with antioxidants. Antioxidants can be most conveniently taken as part of a daily multivitamin supplement that also provides at least 400 micrograms of folic acid and 2,000 IU of vitamin D. It should contain no iron (unless you are a female and having regular menstrual periods) and no vitamin A (retinol). Take these supplements with your largest meal. Women should take supplemental calcium, preferably as calcium citrate, 500 to 700 milligrams a day, depending on their dietary intake of this mineral. Men should avoid supplemental calcium.

Be sure to check with your health care provider before starting this, or any other type of diet plan.

Complications continued from Page 2 (hypercapnia) in the body. In order to boost oxygen delivery, the body compensates in a number of ways:

- Blood vessels in the lung narrow. This leads to high blood pressure in the lungs (pulmonary hypertension).
- More red blood cells are produced to increase the blood's ability to carry oxygen.
- The heart rate increases to pump more blood.
- The breathing rate increases.

These responses can lead to very serious and even life-threatening conditions.

Other complications: Smoking that causes COPD is associated with high risks of pneumonia, lung cancer, stroke and heart attack. Tobacco smoke contains more than 400 substances, many of which are oxidants; metals (such as lead, cadmium, and aluminum, and cancer-causing chemicals (carcinogens). Patients with a 30-year history of smoking and signs of limited airflow (most patients with COPD) are at high risk for lung cancer.

Sleep disturbance: Half of all people with severe COPD experience sleep disorders such as sleep-related hypoxia or insomnia. It may be due to suppression of cough reflex and build-up of mucus. Nocturnal hypoxia is treated with overnight oxygen therapy. COPD patients should not use sleep medications.

Osteoporosis: Thin and weakened bones is a significant problem in patients with COPD. Many conditions associated with COPD, including smoking, lack of vitamin D, sedentary lifestyle and the use of corticosteroid medications put people at risk for bone density loss and osteoporosis.

COPD affects an estimated 340 million people worldwide. It is the fourth most common cause of death in North America but experts predict that it will be the third leading cause of death in the world by 2020 as the population ages and people continue to smoke.

— Mary Layton

Join today: The COPD Canada web site is your portal to our association, new and varied educational materials, medical resources and community interaction. **Membership is free of charge** for individuals living with COPD or their caregivers.

Joining is fast and easy! Visit our web site www.copdcanada.info, click on membership and follow the step by step instructions. **Once you've joined** you will receive our quarterly "Living with COPD" newsletter and will have complimentary access to all COPD Canada seminars, on-line discussion forums and our member chat section.

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people

Kathy Clarke

Kathy has always believed that dreams come true. In grade five she decided to become an archaeologist and work at the Royal Ontario Museum. So she left small town Ontario and studied Art & Archaeology at the University of Toronto—eventually becoming Exhibition Officer at the ROM and taking part in one actual archaeological dig and travelling throughout Egypt.

There were competing dreams. A fondness for theatre led to two seasons in the Stratford Festival Prop Shop. Stumbling upon her radical social consciousness—these were the 60s after all—she worked for two years in the offices of the Campaign for Nuclear Disarmament.

More mainstream stints at the Unitarian Service Committee and CJOH TV in Ottawa eventually led back to the Museum where her future husband was waiting in the Planetarium.

In time Kathy became a delighted “At Home Mom” to two great kids, now 30 and 28, who keep her plugged into contemporary culture. When she finally rejoined the workforce 9.3 years before retirement, she chose the gentle occupation of church secretary and was a friendly face at the church’s food bank while adjusting (with only modest success) to the computer.

When were you diagnosed with COPD?

I attributed my shortness of breath to aging and smoking and had actually already quit cold turkey (May 15, 2003), two years prior to diagnosis. In 2005 my doctor advised me that I had emphysema but took no action. A year later I insisted on getting help and received a pulmonary function test. The technician said ‘Oh dear’ when my FEV1 was 47% of predicted. I cried a little and then called the Lung Association.

How long did you smoke?

I have a letter I wrote on unlucky Friday Nov. 13, 1959 which pinpoints the exact moment my 44 year habit began. “The cutest guy in the play offered me my first college cigarette. Don’t worry”.

How did you find out about the Pulmonary Rehabilitation program at Toronto Western Hospital?

My daughter-in-law is a nurse and told me I must apply. I printed out online information, showed it to my doctor and got him to refer me.

Do you find it helpful

Incredibly so! I’m in better shape than I’ve ever been, what with those exercise machines and weights. Also useful are the insights gained into oxygen use and what the future holds. It’s a gift to have a place where you can get your questions answered and where there is always laughter.

What other educational resources are available?

We are made aware of other opportunities such as an evening at Queen’s Park with MPPs to promote awareness; or the lecture

and elegant reception of the American Thoracic Society; or the Patient Forum at Harbour Castle organized by the Ontario Lung Association which offered pancake-sized cookies along with a fine view of planes, sea gulls and choppy water.

How are you feeling?

My FEV1 has remained pretty stable in the mid to high 40s, though it once dropped to the mid 30s. I appreciate being able to take long walks and manage public transit.

How do you stay busy?

I curl up on the couch to read, knit, watch TV. I walk, dine out, go to movies, have family visits, email friends and write weekly letters for Amnesty International, also volunteering in their office.

Do you ever get answers to the letters you write for Amnesty?

Rarely. The most dramatic response was from an Algerian detainee in Guantanamo forwarded to me by the International Committee of the Red Cross.

Do you ever attend demonstrations these days?

When I do, I stand beside the singing group “The Raging Grannies”. I enjoyed supporting the Grassy Narrows natives in their logging dispute at Queen’s Park where one of the native participants was wearing a T-shirt picturing Geronimo and warriors, reading “Fighting Terrorism since 1492”.

Do you have any unfulfilled dreams?

Visiting Pompeii... though not hiking up Vesuvius. I’m concentrating on what life offers. Tomatoes from my husband’s garden. Good air quality. Happy children.

Want to see what full service respiratory care looks like?



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