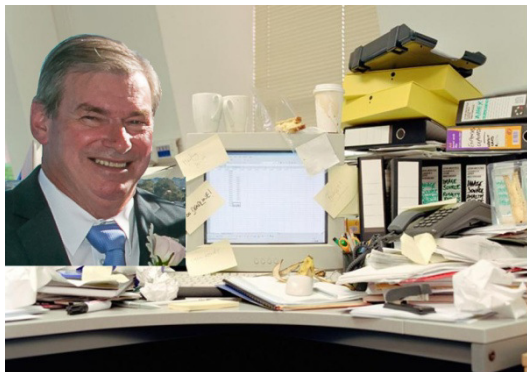




RECOVERY

GBS / CIDP
GUILLAIN BARRE SYNDROME
CHRONIC INFLAMMATORY DEMYELINATING POLYRADICULONEUROPATHY



From The Editor's Desk

Hello and welcome to the June edition of Recovery, the first with me as editor. I hope you find the contents both interesting and informative.

Before I go any further I would like to acknowledge Christine and congratulate her on the fine job she has done previously as editor. Christine continues her roles as Treasurer, Public Officer and Website Facilitator.

My life and that of my family changed dramatically on the 1st March 2008, the day I went to the ED of Nepean Hospital and was diagnosed with Guillain Barre Syndrome. I had never heard of it. As my condition deteriorated so rapidly, I felt so alone, wondering if I'd live or die.

Having a loving family was my rock but they didn't know any more than I did. I was blessed to have a wonderful lady visit. You see, she had suffered from GBS some years previously and, she showed me that there was a light at the end of the tunnel and, mercifully, it wasn't a train. She showed me there was recovery.

My story, which I will share another time, is not unlike many others yet as different as many are. Hospital visits, information and communication are part of recovery. I'm pleased to be a part of this association and hope that I can help others by offering support to patients and their families.

At the time of writing I am visiting 2 patients in hospital, 1 of whom has been in hospital for more than a year including rehab for approximately 6 months. The other is in his final days in ICU before heading off to the rehab ward.

In this month's edition, new committee member, Eliette Roslin, shares her story. Another new committee member, Trish Brice, tells why she joined the GBS Association.

In early May I had the privilege of giving a presentation to 3rd year occupational therapy students at the Australian Catholic University's North Sydney Campus. It was also teleconferenced to the Melbourne Campus. The subject was Neurological Disorders - diagnosis, treatment, recovery and living with.

Students from both campuses were attentive and happy to ask questions. The feedback I received was positive. I look forward to making more presentations in the future. Jane also gives a presentation to the Cumberland College each year. It's something we both enjoy and look forward to continuing.

If you have a story or information you'd like to share you can send it to me via mail or email, either through the association or to me direct, my details are on the back page.

Ken



In this issue

- Page 2: Chairman's Message
- Page 3: Letter from the National Blood Authority
- Page 4: My Story - Eliette Roslin
- Page 5: Why I joined - Trish Brice
GBS/CIDP Variant
- Page 7: Ask the Doctor
- Page 8: Back Page Bits 'n' Pieces

Next Meeting: 1st August 2015
'Susan Schardt Conference Room' L1
Royal Rehabilitation Centre Sydney
235 Morrison Road, Ryde

9:30 - 11:00 Committee business and administration
11:00 - 12:30 Open Forum for members and family / guest speaker
Visitors are welcome to both sessions or the Open Forum only if preferred



website: www.gbs-cidp-nsw.org.au
email: info@gbs-cidp-nsw.org.au

Message from the Chair

Welcome to our winter edition of Recovery. I know winter is upon us without looking as my colder than normal fingers and toes tell me it is time to dig out the ugg boots and doona. Winter is especially not a good time to be suffering the ongoing impact of GBS/CIDP and it often seems Mother Nature is underlining the cruel lottery that is acquiring GBS/CIDP.

However, the Association held its AGM recently and the positive news ensuing from that meeting is enough to cast a warm glow over a cold peripheral nerve or two. As I am writing this article again it indicates I have been re-elected Chair. Further, we have a number of new committee members on deck in the form of Ken who is the new Editor of Recovery. As you will be aware Christine has long held a number of Committee roles including Editor, Treasurer, Webmaster and Public Officer and it gladdens me no end that Ken has stepped forward to fill some very large shoes.

Christine has worked tirelessly to ensure our newsletter is both relevant, interesting and readable. I have often said you could put it on a newsstand alongside other glossy magazines, put a price on it and it would sell. Our newsletter punches well above its weight compared to the newsletters of many other support groups and charities. Christine has set a high benchmark and I look forward to seeing what Ken can do to put his own stamp on our flagship publication. Christine continues in her other roles on the Committee and we are immensely grateful for her past and ongoing commitment to the Association.

Trish also joins the Committee as Minute Secretary. As you will be aware our beloved Ronald passed away last year and Mary, our phone a friend support officer, kindly stepped in as Minute Secretary when Ronald could no longer attend meetings due to his deteriorating condition. As most of you will be aware Mary is the calm voice at the end of the phone when someone rings the Association for information/support, which is often an emotionally challenging role. Taking on the minute taking role as well was a big ask. As we only meet 4 times a year there is a lot of Administration and other business to get through and sorting out the waffle from the key points can tax the patience and frazzle the nerves. The finished product belies the amount of time taken to compile the minutes. Many thanks to Mary for stepping in at such a personally emotional time and we welcome Trish on board.

Eliette joins us on the General Committee and we are very pleased to have a member of the 'younger' generation on board. As Chair one of my roles is to look forward to leadership succession and business continuity. Who will lead the Association into the future and to ensure the Association is viable both financially and with sufficient membership? Further, GBS/CIDP can strike at any age and with the Committee generally middle aged and beyond (but young at heart) my thoughts are often challenged as to how we can be more relevant to younger sufferers or is the resilience of youth a factor.

As Chair this AGM resolved a number of long standing concerns around the composition of the Committee. With the influx of 'new blood' within the Committee and the experience of older hands as well, we are well placed to further explore the potential of the Association.

In conclusion, on a historical note next year will see the centenary of GBS when discoveries by Georges Guillain, Jean Alexandre Barre and Andre Strohl subsequently led to the name Guillain Barre Syndrome. I feel we should celebrate the event in some way and any suggestions are welcome.

Kind Regards

Mark.



"Winter is especially not a good time to be suffering the ongoing impact of GBS/CIDP and it often seems Mother Nature is underlining the cruel lottery that is acquiring GBS/CIDP."

"... my thoughts are often challenged as to how we can be more relevant to younger sufferers or is the resilience of youth a factor."



Mr Mark Kunach
Chairman
Guillain-Barré Syndrome Association of NSW
Delivered by email: info@gbg-cidp-nsw.org.au

Dear Mr Kunach

PUBLIC CONSULTATION FOR PROPOSED CHANGES TO THE CRITERIA FOR THE CLINICAL USE OF INTRAVENOUS IMMUNOGLOBULIN IN AUSTRALIA

I am writing to advise you of an impending six week public consultation for proposed changes to the *Criteria for the clinical use of intravenous immunoglobulin in Australia, second edition* (Criteria).

The public consultation process will commence on **15 June 2015** and conclude on **26 July 2015**.

You may be aware that governments determined the Criteria, first published in 2007 and updated in 2012, to ensure that government funded immunoglobulin products are directed to patients whom are most likely to benefit based on reliable evidence or where alternative therapies are limited. The medical conditions from Chapters 5 & 6 of the Criteria have recently been reviewed by Specialist Working Groups (SWGs) for Haematology, Immunology, Neurology and Transplantation Medicine. These four SWGs have been established to provide advice and make recommendations to the National Blood Authority (NBA) to support measures to strengthen immunoglobulin product authorisation and management. Initial feedback has also been sought and incorporated from Dermatology and Rheumatology specialists for the associated medical conditions.

The proposed changes to the Criteria can be viewed online at
<https://test.blood.gov.au/UAT/IgPublicConsultation/>.

A feedback template will be made available on the NBA website at
<http://blood.gov.au/public-consultation> and should be provided by email to
IgGovernance@blood.gov.au by 5:00pm Monday 27 July 2015.

We would be grateful if you could assist in communicating the details of the public consultation to your membership.

If you have any questions or concerns please call the NBA Immunoglobulin Governance Team on 02 6151 5031 or email IgGovernance@blood.gov.au.

Yours sincerely

A handwritten signature in black ink, appearing to read "LMcJames".

Leigh McJames
General Manager

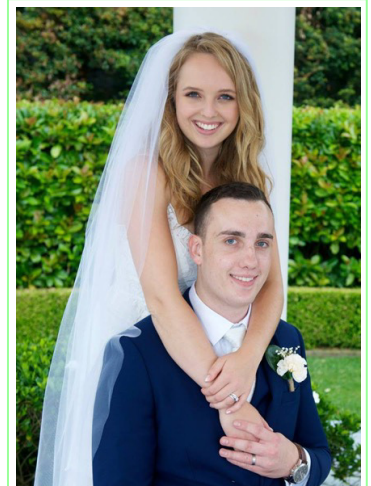
13 May 2015

My Story - Eliette Rostin

On the 24th of August 2010 at the age of 16 I fell sick with a cold. With slight dizziness and a sore ear I'm not sure you could even call it that. Over run and tired there was never a spare moment, and I liked it that way – busy was my "thing". However by the afternoon the dizziness had taken over and I was finding myself absolutely exhausted.

The next day I didn't have the energy to get out of bed, locked away in my room, my body forced me sleep it off. My mum carried me to the doctors out of pure horror and he prescribed antibiotics for my earache. The next day the earache was gone but I was faced with numb feet, numb hands, double vision and half of a numb face. I went back to my doctor who was shocked and said if it got any worse, to go to the hospital that night.

By 11pm I could no longer hold down any liquids and we raced to the ER. Fragile and weak my mum once again carried me through the doors and by 2am I had received a chest scan, CT scan and a spinal tap.



Eliette on her Wedding Day with husband Lukas

The morning of the 27th rolled around and it was time for the diagnosis. The neurologist came over, checked my reflexes and diagnosed me with Miller Fisher Variant of GBS; too me that meant nothing. I couldn't comprehend what he was saying and as it went in one ear and out the other he tried to explain that my body was slowly deteriorating and I may not be able to walk for a while but that I could bounce back. We then got moved to the ward to have a white blood cell transfusion to try and boost my immune system but by that evening I was no longer able to breathe, swallow or speak. I was raced to ICU where they induced me into a coma and placed me on life support. 4 days later I woke up and couldn't move a single thing in my body, not even my eyes.

The first week is a total blur, but by the time the second week rolled around things slowly started to pick up. I was able to open my eyes but the double vision was still present and the pain was starting to be more prominent, I also discovered I was allergic to a medication after suffering 3 cardiac arrests. I never thought whilst being paralysed one can be so uncomfortable. How can you have cramp in your leg and feel it when you can't feel someone holding your hand? If the nurses were to touch my legs it was as if they were coming at me with a knife, stabbing me a thousand times over. Baths were my favourite time of the day, sitting in the water was my meditation and I always begged my nurses for longer.

The support from friends and family was over whelming, I was never alone and we always had music playing. They made it seem like nothing was wrong and that everything was going to be just fine, talking about life as usual, filling me in on everything that was going on. My mentality was very focused on a quick recovery and I think it was mainly because everyone led me to believe that that could be the case. The doctors were sceptical of false hope and always held back but they pushed and encourage in their doctorly way, especially when it came to weening me off my life support.

After a month I was able to breathe on my own and could move my head, shoulders and my right hand ever so slightly and was transferred to HDU followed by general ward. Here we started working on fine motor skills like brushing my hair, feeding myself, weening me off my feeding tube and stomach nose drain (I suffered from severe nausea). I started to realise over this period that the work that was to go into my recovery was going to be a lot harder than first anticipated. I had worked up in my head that one day I'd wake up and things would just work, this of course was not the case.

During my time spent on the ward I had a visit from a girl who also was recovering from GBS, she was 8 months in and I'll never forget the time we spent together that afternoon. I don't think I would've recovered so quickly if it weren't for her encouragement.

After a month on the general ward I was able to head to rehab. This was probably my biggest challenge because they were not only trying to recuperate you but wanting you to get into the swing of normal life. Physio became more intense with 3 sessions a day, each being an hour long. At this point I couldn't stand (and when I say stand I mean held up by 3 physios) for longer than 2 minutes without blacking out. However I kept pushing myself for better results every day and 3 weeks into my rehabilitation I walked out of my gym with the help of my walking frame. My doctors, nurses, physios and OTs were absolutely gob smacked and couldn't believe their eyes but the whole time I was telling them I

could and I would.

A week later I went home on crutches. Since my experience with GBS I managed to finish my last year of high school, travel to Amsterdam for my OE for a year abroad, study full time and graduate with a Bachelor of Music and married this year to the love of my life. I strongly believe that you are capable of achieving anything you set your mind too and that nothing in this life can hold any one of us back. I feel blessed that I can now appreciate life to the fullest and never take a day for granted.



Eliette in ICU

Why I Joined The GBS Association - Trish Brice

I joined the GBS / CIDP Association in late 2014 because I believe that I can make a contribution to the development of the group which my late husband, David Brice, helped to establish.

My professional background is that of Secondary Education, from which I am now retired. Since then I have worked on a Seminar Team for SCIA (Spinal Cord Injuries Australia), do part-time child care work, assist in the Archives at my former school and volunteer for a Mainly Music group for mothers and babies at my local church.

My interest in advocacy in disability commenced after I met David in 1993. I had no knowledge of GBS then. He wore callipers at that time because of severe foot-drop, a consequence of successive attacks of GBS which continued after our marriage in 1997. His was a very rare case history.

What became very evident to me, through David, was the resourcefulness and resilience of people with a physical disability-their ability to lobby at local, state and federal levels to break down barriers and to help secure equality in the areas of health, access, transport, housing and employment. That is what he did at both a personal and professional level.

It would be my hope that in some way I could contribute to the Association in any way to use what I have learnt from my experiences living with David. His impact on the way I now live my life is immeasurable.

GBS/CIDP Variant : Anti-MAG Peripheral Neuropathy

What is Anti-MAG peripheral neuropathy? Anti-MAG peripheral neuropathy is a very rare disease, constituting perhaps 5% of CIDP-like disorders. Anti-MAG occurs when the body's own immune system develops antibodies against a key glycoprotein (myelin-associated glycoprotein, or MAG). MAG is essential to maintaining a healthy peripheral nervous system.

The disorder is predominantly characterized by distal sensory loss in the extremities (hands and feet), a tingling sensation in the affected limbs, a mild to moderate tremor, and poor balance which can lead to difficulty walking. As the disease progresses, individuals develop some muscle weakness as well. Ninety percent of patients are male, and most of them are in their 50s or 60s.

Anti-MAG differs from CIDP in that it is not an inflammatory disease, and therefore typical CIDP treatments are usually only transiently effective in these patients.

What causes Anti-MAG? Myelin is an important part of the peripheral nervous system. It wraps around the nerve axon (the long, wire-like part of a nerve cell) much like insulation around an electrical wire. The nerves extend from the spinal cord to the rest of the body, stimulating muscle contraction and transmitting sensory information back to the nervous system receptors in the skin and joints. This insulation (myelin) allows electrical impulses to efficiently travel along the nerve axon. When myelin is damaged or removed, these electrical impulses are slowed or lost, much like a faulty wire would allow leakage of electricity and loss of electrical current.

MAG is a special type of glycoprotein that is found within the myelin sheath and in Schwann cells, which are the cells that are responsible for creating and maintaining myelin sheaths on nerve axons. It is thought that MAG plays a role in a signalling cascade that "turns on" the Schwann cells, leading to normal myelin production and healthy peripheral nerve activity.

continued page 6

from page 5

In anti-MAG peripheral neuropathy, the body produces serum IgM antibodies that bind to MAG, preventing MAG from signalling the Schwann cells and myelin to do their job. This results in the loss of the nerves' normal function, leading to problems in both sensory and motor function.

It is still unclear what causes the body to create anti-MAG antibodies in the first place. In about 98% of cases, the anti-MAG antibodies are the result of an abnormal expansion (increase in numbers) of a single antibody-producing cell. This condition is called monoclonal gammopathy. Monoclonal gammopathies are the irregular proteins produced by these cells. These proteins are called immunoglobulins and there are different types; Immunoglobulin G (IgG), IgA, IgM, IgD and IgE. In anti-MAG neuropathy the monoclonal gammopathy is IgM. Most monoclonal gammopathies are not associated with neuropathies or any other disease but occasionally they can be malignant. Your neurologist may refer you to a haematologist to rule out other diseases.

How is Anti-MAG diagnosed? Detecting anti-MAG neuropathy starts with identifying the symptoms of the patient:

- Sensory loss starting in toes in fingers
- Loss of vibration senses
- Unsteady gait
- Tremors in hands and legs

Diagnosis proceeds with a neurological examination. If the examination indicates that the patient has a peripheral neuropathy then testing for an IgM monoclonal gammopathy and electrodiagnostic testing is done. If the blood work and/or the EMG are appropriately abnormal then blood testing for anti-MAG neuropathy is done. Other blood work will be done to exclude another cause for the patient's condition. Some patients will have an elevated protein in their cerebral-spinal fluid, which can be obtained through a spinal tap.

How is Anti-MAG treated? There are many therapeutic treatments that have been used for anti-MAG neuropathy. Most of these treatments are thought to reduce the levels of anti-MAG antibodies.

- Rituximab: One of the most promising treatment options, it is itself an antibody that binds to B- cells (cells that make antibodies) and removes them from the blood, cutting off the production of anti-MAG antibodies at the source. Studies have been inconclusive but there is a suggestion that most patients experience an increase in sensory and motor abilities within the first few months of therapy. However there is a risk that other infections and diseases could occur that would normally be prevented by an intact immune system. Usually this is not prescribed unless symptoms become severe.
- Cyclophosphamide: Cyclophosphamide is a drug often used in the treatment of lymphomas. It works by killing rapidly dividing cells such as antibody-producing B-cells, which in turn decreases antibody levels. This leads to significant improvements in people with anti-MAG neuropathy in relieving sensory loss and helping to improve quality of life in a few short months. There is, however, a long-term risk of cancer with chronic use of this treatment.
- IVIg (Intravenous Immunoglobulin): IVIg infusions help only a small segment of patients in the initial phase of the disease. It is not very effective in treating anti-MAG neuropathies.
- Steroids and plasma exchange treatments are not recommended for anti-MAG.
- Other agents that target lymphocytes and particularly B cells are considered on an individual basis. This is frequently done in collaboration with a haematologist.

Current immune therapies—while temporarily effective in some patients—are associated with considerable side effects which limit their prolonged use and efficacy. They should be reserved for patients impaired in their daily activities or for patients in a progressive phase of the disease.

Living with Anti-MAG. The progression of anti-MAG is slower and less severe than CIDP, and many patients continue living relatively normal lives while managing their symptoms with simple exercises or drug therapies. Usually, only 10 percent of patients become severely disabled and wheelchair-bound.

The information contained in this article was sourced from the GBS-CIDP Foundation International's website and has been printed with their kind permission.

Ask the Doctor

Joel S. Steinberg PhD. (Dr Steinberg is a former GBS Patient, Vice President of the GBS-CIDP Foundation International Board of Directors and a member of the Medical Advisory Board)

SAFETY OF IMMUNIZATIONS

Question: Should I have a flu shot if I have had GBS or CIDP? Should my family members have the flu shot also?

Reply: Administration of the 1976 swine flu immunization was followed by a much greater than expected number of cases of GBS in recipients. This scenario has not recurred. But that event did raise concerns about the safety of influenza as well as other immunizations. The general teaching on this matter is as follows: If an individual's case of GBS followed shortly, within 6 weeks, of having received a flu shot or other immunization, that injection should likely not be given again. Otherwise, most immunizations, including the flu shot are usually safe. And their benefits usually far outweigh their risks. As to CIDP, there is no evidence that this is triggered by flu or other immunizations. Since CIDP develops slowly, often over months, it is usually quite difficult to ascribe the disorder to a specific event such as an immunization. In short, having had CIDP is not a known contraindication to receiving the flu shot. For both GBS and CIDP patients the decision about administering immunizations is best made by the family physician who can take into consideration the patients' various other medical issues. There is no evidence that family members of former GBS and CIDP patients are at increased risk to develop these disorders from immunizations. Therefore it will usually be safe for them to get the flu shot if they fulfil standard criteria to receive it.

RELAPSE FROM GBS

Question: Mr. RB asks about a potential complication or aftermath of GBS that is likely on the minds of many former GBS patients. He expresses concerns about relapse and wonders how common it is, what the symptoms are, and what can be done about it. He relates experiencing, from time to time, tingling or numbness in the soles of the feet, wondering if this is a sign that GBS is coming back. He understands that about 10% of GBS patients have a relapse, and wonders how to distinguish tingling sensations that pass from those that presage an attack.

Reply: Mr. B raises important issues, of natural concern to former GBS patients. Let's first discuss 'relapse' One can look upon a true 'relapse' as a deterioration or reversal of symptoms, in the form of recurrent weakness and/or abnormal sensations that is experienced early in the course of recovery from GBS. In the typical GBS case, the patient deteriorates, from their normal state, by developing progressive weakness, usually accompanied by abnormal sensations (tingling, numbness, formications [a sense of worms or ants crawling under the skin], even pain), over several days to at most four weeks, until this deterioration stops. In most patients, about two thirds of them, weakness ascends the body, leading to inability to walk and even weakness of the arms. In about a third of patients, weakness progresses up the body to involve the breathing muscles, requiring mechanical ventilation, with the use of a respirator, for days to weeks. In both situations, once weakness maximizes, the patient plateaus for hours, and barely noticeable, to days or longer. This is followed by steady recovery. During this recovery often early on. within its first few days to weeks, that relapse can occur. And this relapse, which occurs in perhaps 10% of patients, can be severe enough to require re-intubation and mechanical ventilation. So relapse can be serious. Once the relapse has plateaued, improvement of strength gain resumes, often steadily. It is helpful early in the recovery phase, for physicians to be on the lookout for deterioration, in case breathing collapses.

After the patient has recovered, which in most people (up to 75%) can be a full recovery, there are some potential further scenarios. A small percentage of 'recovered' patients may experience ongoing fatigue and/or abnormal sensations, such as tingling. Fatigue is often treated with paced activities. Abnormal sensations are sometimes improved with such medications as gabapentin (Neurontin) or pregabalin (Lyrica).

Up to 3% of recovered GBS patients may incur a true second episode or case of GBS. And occasionally a recovered patient may experience a recurrence of abnormal sensations and/or weakness and think it is their GBS coming back again, when it is actually something else. These patients, essentially all patients who have recovered from GBS and again get sensation abnormalities, warrant a new look and evaluation of their symptoms. Do not automatically expect the recurrent symptoms to be due to a recurrence of GBS. Sometimes new weakness and/or sensations changes can reflect newly evolving CIDP, the chronic cousin of GBS. Or an entirely different disorder may be developing. The diagnostic possibilities are not that small, including diabetes, underactive thyroid gland, etc. It is often wise to have a physician familiar with GBS examine the patient, to look for these various disorders that could in part mimic a recurrence of GBS.

Sourced from the GBS-CIDP Foundation International's website and has been printed with their kind permission.

Back Page Bits 'n' Pieces

GBS Association of NSW

A NON-PROFIT VOLUNTEER ORGANISATION

Registered ABN: 59 166 877 537

Incorporation No. Y13693---18

COMMITTEE

PATRON:

Ursula Carlile

CHAIRMAN:

Mark Kunach

DEPUTY CHAIR:

Atilla De Szoek

TREASURER & PUBLIC OFFICER:

Christine Simpson-Morgan

SECRETARY:

Glenda Ford

MINUTE SECRETARY:

Ronald Nichols

GENERAL:

Mary McAlister
Jane Rothman
Wendy Burge
Eliette Roslin

EDITOR:

Ken Brooke

SUB-EDITOR:

Mary McAlister

WEBSITE ADMINISTRATION:

Peter Russell and
Christine Simpson-Morgan

MAIL:

PO Box 572
Epping NSW 1710

PHONE ENQUIRIES:

(02) 9617 0883
0487 843 723

EMAIL:

info@gsb-cidp-nsw.org.au

WEBSITE:

www.gbs-cidp-nsw.org.au

ANNUAL SUBSCRIPTION / DONATIONS

Financial Year 1st January 2015 to 31st December 2015

Name:

Address:

Address:

Phone / Mobile:

☐ Please send my *Recovery Newsletter* via email.
email address:

Please indicate your interest

☐

GBS

☐

CIDP

☐

Doctor/Medical

☐

Relative

Direct Deposit: Guillain Barre Association Inc

Bank Account: St George 261565 BSB: 112-879

Cheques payable to: **The GBS Association of NSW Inc**

PO Box 572, EPPING NSW 2121

Note: Donations of \$2.00 or more are tax deductible. ABN: 59 166 877 537

Annual Subscription Renewal

\$ 20.00

Donation

\$

Total

\$

Please let us know if you would like to volunteer for your Association

We need your help to really make our Association supportive and effective. We are here for you – all on a volunteer basis. Can you be there for those who are going through what you did, or are still going through?

Name:

Address:

Address:

Phone / Mobile:

email address:

Hospital or home visits to new sufferers (remember how you felt)

☐

Preferred area:

☐

Telephone contact (be a GBS or CIDP friend by phone)

Preferred contact number:

Committee Meetings

All are welcome to attend the GBS Association of NSW Committee meetings. Newly diagnosed and people recovering from GBS and CIDP will appreciate the contact, encouragement and support from fellow members.

2015 Meeting Dates

7 th February	2 nd May AGM	1 st August	7 th November
--------------------------	-------------------------	------------------------	--------------------------

Financial Year 2014

Members are reminded the Association's financial year is

1st January 2015 to 31st December 2015

GBS NSW would appreciate your continued support.

Disclaimer

Information presented in "Recovery", GBS Newsletter is intended for information sharing and general educational purposes and should not be considered as advising, diagnosing or treatment of the Guillain-Barre Syndrome or any other medical condition. Views expressed in articles and letters printed in Recovery are those of the authors and do not necessarily reflect the opinions or Policy of the GBS Association of NSW Inc.

Public Risk

The Guillain-Barre Association of NSW would like to inform all members, friends, guests and readers that the Association no longer has Public Risk insurance covering association meetings or association functions. We regret that due to increased costs we were unable to renew our Public Risk Insurance.

Contact the Editor

Do you have an interesting story to share with your fellow members? Perhaps you would like to share your experience with GBS/CIDP with us by writing your story for 'Recovery'. Maybe you just need some more information on an article appearing in the Newsletter? Whatever it may be you can contact Ken Brooke:

Mail: 16 Corio Drive ST CLAIR NSW 2759

Email: kbrooke53@gmail.com