A while ago, one of our members, while in an Emergency room for a severe exacerbation, was told by a doctor that “It was all her fault for having smoked.”

While such a statement coming from one who is supposedly a trained professional is at least shocking it is, sadly, an occurrence which is far too common. I have faced this attitude as have many others.

I would like to discuss here what are (in my mind) the two primary causes of this attitude.

The doctor graduating today has never known a time without personal computers. Or microwave ovens, cable television (and remote controls), compact discs, (although they are becoming outmoded) seatbelts and airbags in vehicles or cellular phones. They have also not known times when smoking was pervasive throughout our society. One could, and did, smoke almost anywhere. At work, in movie theatres, restaurants, planes and long distance buses. There were ashtrays in doctors offices and in patients hospital rooms. Churches, city buses and some industrial places (in my experience) were the only places you weren’t allowed to smoke.

In the mid Sixties, however, that started to change. What was the largest, and arguably most successful social engineering project ever undertaken in North America started. Slowly at first, the places where smoking was allowed started to dwindle. I remember my father being absolutely incensed that he was no longer allowed to light up while grocery shopping. Soon, to smoke one had to go to the side seats in theatres. Ashtrays disappeared from patients rooms and were placed in designated smoking rooms then to areas outdoors to nowhere on the grounds. Restaurants began having smoking areas set aside and smoking was no longer allowed on aircraft.

In the ‘70s however the pace picked up. Smokers were starting to be given a negative image. In movies, the bad guys black hat was traded for a cigarette. I feel this is the point where the bathwater went out, complete with the baby. More and more the lines blurred between tobacco and the people using it being the bad thing. This is the culture the newer doctors were raised in. Intolerant of the habit or the people who have it. Smokers, even former ones, have become perhaps the last people it is legal to discriminate against.

A survey was distributed to all grades of doctors attending routine postgraduate events at five hospitals. It described four patient scenarios including (a) current excess alcohol drinker limited by complications, (b) current cigarette smoker limited by angina, (c) current intravenous drug user limited by complications, (d) current cigarette smoker limited by COPD. All had previously been offered relevant lifestyle advice and cessation services.

This bias against COPD, when combined with the, at best, unsympathetic attitude toward smokers has created a hostile atmosphere around COPD patients. In a study conducted by Drs. Winstanley, Daunt and McFarlane, the majority of doctors surveyed put COPD patients at fault for their condition.

This survey compared doctors’ attitudes towards different patient groups: smokers with COPD, smokers with angina, alcoholics and intravenous drug users (IVDU).

Even longer standing than the above is the medical establishments bias against COPD. Doctors want to fix things. We (COPD patients) don’t fix, and it is, I’m sure, an aggravation to many doctors. Again, however, the lines between the disease and the patient have become blurred. As a result, we have been dehumanized. I feel this was done to make it easier to not get too emotionally invested in patients that there was nothing that could be done for.

The classic division of us by symptoms reduced us from people to pink puffers or blue bloaters. It also brought about the term “End Stage”. In Victorian times, part of medical training was to parade patients with various conditions across a stage. (Think back to Elephant Man) The various diseases and their remedies would be discussed with the students. Because nothing could be done for COPD sufferers, they would be brought up last so as not to take away time from the discussion of treatable conditions. These people were at the end stage. They had time left (not as much as they would today) they just weren’t treatable. While bloaters and puffers are rarely heard of nowadays, some “old school” doctors still demoralize and frighten patients with the “End Stage” term.

‘Their current condition is largely their own fault’. Most doctors (145, 79%), agreed/strongly agreed that current smokers with COPD were the most at fault for their condition.
This was a significantly greater proportion than those believing alcoholics were at fault (125, 68%) and more than intravenous drug users, (137,74%) and smokers with angina (112, 61%)"

As many of us can attest, this attitude carries over to former smokers as well.

What can be done? If we find ourselves in the situation we need to immediately let the offending person know that we will not accept their behavior. Within a short time of our release from the ER, supervisory staff of the unit need to be notified of the incident, preferably in writing. As well, let hospital management know, in writing of the incident and your feelings of its unacceptability. Lastly, ask any advocate you may have (such as this organization) to contact the hospital. A lot of effort some may say, but with a good attitude being proven to help in control of any disease, the elimination of verbal assault by people who are supposed to be assisting us goes a long way toward maintaining both health that is as good as it can be given the circumstance as well as a quality of life unburdened by guilt.

The key thing though in my opinion is to go by the proverb that people can only hurt us as much as we allow them to. While smoking is indeed the major culprit in this disease, the fact that we have it is NOT our fault! Not all smokers end up with COPD any more than every person who makes poor dietary choices becomes diabetic. It is a disease...an impersonal throw of the dice. We are no more to blame for getting it that we would be for catching a cold or getting dysentery from bad water.

I hope that any medical people reading this don’t feel that I have tarred them all with the same brush. The vast majority of doctors, nurses and other health care providers are compassionate people who are careful of the feelings of patients. Indeed, when the member who was mistreated mentioned it in the forum, many people were aghast, having never received such treatment. It is my hope that the “bad apples” are dealt with and none of us ever have to experience such insult.

Seek out those supportive groups, clinics and people in your community that know about chronic lung conditions, and have the knowledge and compassion to share with you. And know that COPD is NOT a death sentence. It is a chronic condition, that can be well-managed, and the more knowledge YOU have about this condition, the more you can educate those around you. Write letters to your local government, telling them we need spirometry done more often to help diagnosis this condition earlier; we need settings such as Respiratory Clinics to provide patient education and support; and we need more access to treatment options such as Pulmonary Rehabilitation. ‘COPD-A National Report Card' reports that only 1.2% of the entire COPD population are being served by Pulmonary Rehabilitation programs[2]. If we expect satisfaction from those caring for individuals with COPD, compassion should be a ‘given’, but those same health professionals need to have confidence that our government supports preventing, screening for, and treating/managing COPD so these many patients who will be diagnosed with COPD now and in the future have the opportunity to have the best lung function possible, with the fewest symptoms possible - because there IS life to live, even with a chronic condition.

I hope that any medical people reading this don’t feel that I have tarred them all with the same brush. The vast majority of doctors, nurses and other health care providers are compassionate people who are careful of the feelings of patients. Indeed, when the member who was mistreated mentioned it in the forum, many people were aghast, having never received such treatment. It is my hope that the “bad apples” are dealt with and none of us ever have to experience such insult.

But whatever the reason, the patient with COPD needs to know there is an educator out there that has the knowledge of the progression of the disease, the skills to share in managing the disease, the resources to seek out extra treatment as needed, and the compassion to understand this is a life-changing diagnosis, and support is needed.

If a person is experiencing symptoms with their breathing that seem to be progressing, and have risk factors that may have affected their airways, they need to seek out the ability to have their lung function tested. The earlier COPD is diagnosed, the more successful we are in slowing the natural progression of the disease.

[1] LaCasse Y., Brooks D., Goldstein R.S.
Trends in the epidemiology of COPD in Canada, 1980-

Chronic Obstructive Pulmonary Disease (COPD) is currently the 4th leading cause of death, behind heart disease, cancer and cerebrovascular disease (including stroke). By the year 2020, COPD is expected to surpass cancer, to become the third leading cause of death worldwide. This rate is especially increasing in the female population. A publication titled 'COPD: A National Report Card', reports that 45% of Canadians have never heard of COPD.*

And studies have shown that 50% of patients, remain undiagnosed with COPD. [1]

So then why, does spirometry - a simple breathing test to diagnose COPD continue to be extremely underutilized? This leads to a large number of patients not being diagnosed with the disease, until they are truly symptomatic - meaning, by this time, they have lost so much of their lung function, that are now short of breath with activities that once seemed manageable. That short flight of stairs has now become a challenge to do without feeling winded. Walking in to the doctors office from the parking lot means stopping to catch their breath in the nearest seat available. Household tasks that used to be easily completed one by one on a list, now need to be broken in to something that will take several days to complete.

With this large number of patients being left undiagnosed for several years, now managing their symptoms has become a challenge. I perform office spirometry in my Family Health Team setting. Before starting this Respiratory Clinic, the only option for lung function testing (in a community of 28,000, with an area surrounding the city servicing several thousand more), was to have full Pulmonary Function Tests done at the hospital. This of course meant long wait times, and only the 'sickest' patients would be referred.

The goal of managing respiratory care, should be to diagnose patients earlier, before so much lung function is lost that they are experiencing regular symptoms that now disrupt what they want and need to do. Patients that I assess are often alarmed at being diagnosed with a chronic lung condition. They often ask "Will it ever go away?"; "Is this a death sentence?"

The unfortunate news is that yes - Chronic Obstructive Pulmonary Disease (COPD), is just that - chronic. Meaning, it's not going away. But - with the proper treatment, symptoms can be improved. With the proper patient teaching about self-management, quality of life can be improved - through learning coughing and breathing exercises, how to properly take inhaled medications, managing stress and anxiety, energy management, the use of Action Plans, and the importance of regular exercise...even for those patients short of breath with activity.

For patients diagnosed with COPD, it is important to have access to learning these self-management skills. I teach all these things to my respiratory patients, with the reassurance that - yes, you have COPD...but you have a life to live. Lets learn how to live life with COPD, to continue to make the most of every day of your life, to be able to do the things you want to do, need to do, and love to do, on a daily basis. The more you know about self-management skills, the better your quality of life can be. With good self-management skills including learning about and following an Action Plan, ER visits and hospitalizations for 'flare-ups' or 'exacerbations' of this disease can often be prevented. COPD hospitalization rates are on the rise. Flare-ups are the most frequent cause of medical visits, hospital admissions and death - but with proper patient education and disease management, skills can be learned to prevent flare-ups.

These skills, of course, take much time to learn AND to teach. For those working in acute care settings, their goal is to get you breathing more comfortably...quickly....but the self-management skills are not their specialty to teach...as it takes time, and a knowledge of the patients history that has led them to this point. Yes, smoking is one cause of COPD. But only 20% of all smokers will go to develop COPD. There are many other risk factors - a history of asthma (often with frequent exacerbations through the years, bronchial tubes can end up with damage that progresses to a chronic kind of narrowing...now COPD); lung infections, sudden lung insults (exposure to noxious chemicals or fumes in an accident, exposure to smoke in a fire, etc.); and repeated exposure to inhaled dust, chemicals or fumes over several years, can lead to similar permanent damage inside the bronchial tube. A very small percentage may even have a genetic factor predisposing them to having COPD...no matter what their employment or lifestyle risks.

There will of course be that doctor, that nurse, that family member...who in frustration at not knowing the history of the patients respiratory symptoms, may flip to the 'easy answer' of blaming cigarette smoking. Perhaps they are jaded from caring for a person with lung cancer who despite knowing they had COPD, chose to continue to smoke. Or they have a sister, who, despite having a phlegmy, hacking cough, continues to smoke. Or perhaps it is their overall frustration with lack of attention and funding from their government. The publication 'COPD: A National Report' states 56% of physicians said their government is not making COPD a healthcare priority. Many necessary COPD medications are not covered by drug benefit plans.

CONTINUED ON PAGE 2
It’s been a while since we had to close down our Caregiver’s Forum and even though life has been so busy for me since then, I do miss the camaraderie we had there. I do wish it had worked out for us to continue but God does know best and knew that I just wouldn’t have been able to monitor things after I had shoulder surgery, which happened the first of November. Being in an immobilizing sling for over six weeks definitely gave me a feel for how it is to depend on others. And it definitely gave me a feel for patients who don’t have family close by and face what we all face these days, everyone else is busy and find it hard to stop their lives for someone else, especially if they live a fair distance away.

This time gave me some things to ponder about a topic for this column and hope that I can provide a little insight for some that read this. One thing I discovered is if you are trying to utilize a government agency that provides some home care, you can’t pre-apply for this service. When I called ahead of time to try and have things in place for when I came home, I was told they couldn’t do any intake until I was actually home. This is how things are here in the Niagara region of Ontario and may not be that way everywhere but I was unable to contact the agency until after the fact. I also discovered that it depends on who you talk to as to what type of assistance you may get and it definitely is important to continue to push and insist on help until it happens. Yes, this is wearing on the nerves and physical self but it’s the only way to make sure you get what you’re entitled to. There’s definitely truth in the saying, “the squeaky wheel gets the grease.”

Another thing that seems to envelop us caregivers is the idea that we can do everything “all by myself.” We don’t want to be seen as inadequate or weak, for lack of a better word. We don’t want to bother anyone, don’t want anyone to think bad thoughts about us or most importantly, don’t want to impose on anyone. One hard lesson that I learned was that people don’t offer if they don’t want to truly help and we shortchange ourselves when we deny them giving us a blessing. It’s definitely hard to be “humble” but I learned to take a huge bite of humble pie when it came to accepting offered help. Probably one of the greatest blessings given to me was when my husband’s brother offered to come stay with him while I drove to Cleveland to see my dad after he had heart surgery. I had hesitated asking for the help but really didn’t know what else to do and when I got home from my visit, I discovered that my husband and my brother-in-law had spent the entire weekend reconnecting and sharing some old loves they’d shared when they were younger. This time still makes me smile when I think of the blessing that each of them got from me allowing myself to ask what I felt was the unthinkable.

Burnout is a common phrase these days, whether it’s from your job or anything else you might tire from...but caregivers are especially prone to burnout and I’d like to offer some symptoms to look for:

- Tearfulness
- Feelings of depression
- Feelings of resentment towards your loved one
- Lack of empathy or patience with your loved one
- Irritability
- Sleeplessness
- Too much sleep
- Fatigue
- Physical maladies (headache, stomach pain, muscle tension, heart palpitations, etc.)
- Problems on your job
- Gaining or losing weight

These are just a few symptoms to be on the lookout for and deserve focused attention. Many times, we are secretly wishing that someone would just come in and help without being asked. When that doesn’t happen, we can begin to become angry (usually with other family members who are [sometimes] clueless as to the caregiver’s needs).

Planning for burnout is the first step to preventing it. Don’t wait until the symptoms become overwhelming. Devise a regularly scheduled stress-reducer for yourself as well as your loved one. Routinely take advantage of outside help. Don’t wait for someone to notice that you are stressed out before you get help. Be proactive: ask for help and avoid getting burned out. One thing is for sure, we deserve the time we take for ourselves and it not only benefits us, but our loved ones. Don’t wait until it’s too late to reach out to someone for help and definitely don’t wait until it’s too late. We hurt not only ourselves by doing that, we also hurt our loved ones and that’s the last thing in the world we want to do. Take care of yourself, because if you don’t, no one else will!

As Always—

Hugs,

Mary
Ask The RT
Mark W. Mangus, Sr., BSRC, RRT, RPFT, FAARC

Q. Extra Oxygen, Using a Straw With a Mask

Hi Mark,

Recently I purchased a 3 layer cotton, loose fitting mask to deflect the wind so I could go for walk on nice days that happen to be windy. I tested it out the other night and had some odd reactions and am concerned that, in fact, what I’m doing is safe. Winds were upwards of 45K and so I wore the mask over my oxygen as I would my cold weather mask. Admittedly, I did have to breathe a little harder as you do feel the presence of it and therefore a bit of back pressure but it deflected the wind beautifully. However, as I check my sats when we walk at night I noticed that at 5 LPM I was getting sats of 97-99%, which for me is incredible. Normally at 5 LPM, my sat level is around 91-93% at best when exercising. So, I am a little concerned about how high my sats got and I don’t quite understand why this would happen. Also, I am concerned about retention although my normal co2 by ABG is only 37. Do you think these things are of concern?

It was fabulous to finally get out and walk and I have always loved to feel the wind so I’m hoping this is a safe way to go. This mask was recommended to me from members of another forum and it is meant for those with seasonal/environment sensitivities but does not have any other filter than the cotton. The only side effect I got from the walk was sore muscles around my ribs from breathing so hard. Just having something on my face seems to make me huff and puff a little harder. The other thing I should mention is that throughout the time that I wore my mask my heart rate stayed at about 105-112 which for me, when exercising is fairly low; so I didn’t see increased workload reflected there. Long and short of things Mark, do you think this is safe and why would my sats increase so much; of course always the concern about retention.

Apologies for being long winded,

Shelley

A. Hi Shelley,

What you have serendipitously discovered is the benefit of a technique of which I have advocated for several years that was originally recommended by my friend Ron Peterson. We call it the Peterson Straw Mask, though with your version you did not use the straw component. The mask acts like a reservoir, collecting the oxygen that would otherwise be blown away or at least would dissipate during the time you breathe out. The mask collects it, the result of which is a bolus of that collected gas plus what’s coming in through your cannula. It ends up being front-loaded, or the bulk placed at the beginning of your inspiration, which causes it to be carried the deepest into your lungs. So, your 5 liters becomes more like 7 or 8 liters. So, you are actually making MORE of the 5 liters than you would without use of the mask. I recommend that as a strategy for folks whose oxygen systems cannot meet their demands with “standard use”.

Insofar as the extra oxygen, it is my concerted opinion that it will NOT hurt you one bit! Using lots of oxygen has NEVER been accused of “causing one to begin to retain CO2”. A few folks have mistakenly interpreted it as such. But, that has never been a component of the theory as professed by those who are proponents of it. Now I DO have one small caution. By not using the straw to “exhale” through - - - an action that would send CO2-rich exhaled gases directly out into the environment, instead, your mask is collecting SOME of that CO2-rich exhaled gas. While the oxygen flow is flushing some of it out, you are necessarily “re-breathing” ‘some’ portion of your exhaled gases, and therefore CO2-rich gas. At 37 on your blood gas, it likely doesn’t represent any problem or threat. BUT, you could probable eliminate all chance of re-breathing of exhaled gas by incorporating the straw into your mask. AND, you can use the system EVERY TIME you go walking for exercise, whether or not it is windy. It can either give you higher oxygen saturations during those activities, as you observed with your current method, OR you could decrease your oxygen flow by maybe one liter and still maintain saturations in the 92 – 94 % range, while stretching your supply all the more through the conservation. The only difference is a matter of “comfort”. Many folks find they are significantly more comfortable with saturations of 96 % and up than they are at 90 or 90 %. So it becomes strictly a comfort issue.

To add the straw, you simply get a large bore straw, cut it in half, snip a “t” in the mask and insert the straw through it. When you breathe as you walk, you inhale from gas within the mask and you exhale through the straw.

In any case, I’m glad you use the device and that you get out and exercise. There’s nothing bad about what you’re doing. AND, you should have no reason for concern about either of the two points you raised.

Best Wishes,

Mark
**Healthy Eating**

“Mustard Roasted Salmon”

**Nutritional Information (per serving):**
Calories: 240; Total fat: 9 grams; **Saturated fat**: 1.5 grams; Carbohydrates: 14 grams; Cholesterol: 50 milligrams; Sodium: 125 milligrams; Protein: 25 grams

**Serve With:**

**Herbed Basmati Rice**

**Ingredients**

- 1 cup uncooked long-grain (white) **basmati rice** (recommended: Texmati)
- 1 3/4 cups water
- 3/4 teaspoon kosher salt
- 1 tablespoon unsalted butter
- 1 tablespoon minced fresh dill leaves
- 1 tablespoon minced fresh scallions, white and green parts
- Pinch freshly ground black pepper

**Directions:**

Combine the rice, 1 3/4 cups water, the salt, and butter in a small heavy-bottomed **saucepan**. Bring to a boil over high heat; reduce the heat to low, stir once, and simmer, covered tightly, for 15 minutes. (I need to pull the pot half off the burner to keep it from boiling over.) Turn off the heat and allow the rice to sit covered for 5 minutes. Add the parsley, dill, **scallions**, and pepper. Fluff with a fork, and serve warm.

**Bon Appetit!!**
Bubba’s first military assignment was to a military induction center, and, because he was a good talker, they assigned him the duty of advising new recruits about the government benefits, especially the GI insurance to which they were entitled.

Before long the Captain in charge of the induction center began noticing that Bubba was getting a 99% sign up for the top GI insurance.

This was odd, because it would cost these poor inductees nearly $30.00 per month more for their higher coverage than what the government was already granting.

The Captain decided that he would not ask Bubba about his selling techniques but that he would sit in the back of the room and observe Bubba’s sales pitch.

Bubba stood up before his latest group of inductees and stated, “If you have the normal GI insurance and go to Iraq and are killed, the government pays your beneficiary $6,000. If you take out the supplemental GI insurance (which will cost you an additional $30.00 per month), the government pays your beneficiary $200,000.

“NOW,” Bubba concluded, “which bunch do you think they’re gonna send into battle first?”
REMEMBER

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For additional info on these products and savings, please see our Discounts Page at http://copdcanada.ca/Member_Discounts.htm
Dear Friends,

Another New Year well underway and we hope is proving to be a good one for you. Our main article this month evolved from one of our members having a very unpleasant experience in ER when she was experiencing a bad exacerbation. We felt that this is something we “Don’t talk about” but we should!! We hope you agree and will become or continue to be your own advocates.

Sincerely,

Gwen

This is YOUR newsletter.
email all suggestions or comments to: gwen@copdcanada.ca

Some people just can’t take a hint!!
**Medicines Frequently Used in the Treatment of COPD**

**An Overview of the "TYPES"**

**Remember:** Medicines can't cure the disease, but they can help considerably with your symptoms.

*Disclaimer:* The information below is far from all inclusive. Additionally it has NOT been reviewed by a Dr. It is intended solely for information purposes only. Dosage, alternative medicines, side effects etc are not included nor listed here. It is important that you have your Dr. and/or pharmacist fully explain how these and other medicines work and what to expect. ALWAYS ask questions and speak with your Dr.

"TYPE" Of Medicine What They Do

**BRONCHODILATORS** (short and long lasting types) Relax the muscles around your airways thereby increasing the flow of air. Usually they're inhaled (using puffers) but some can be taken by pill, liquids or in nebulizers.

- Short Acting Bronchodilators (Beta-2 Agonists) provide relief within a few minutes by relaxing the smooth muscles. However; the effects of them only last 4-6 hours.

- Long Acting Bronchodilators can last 12 - 24 hours depending on the product. Quite often they're referred to as "controllers" or "maintenance medicines."

Oral Bronchodilators are taken by mouth and work to relax the muscles around the airways. They help to relieve breathlessness. Quite often they're used to help the inhaled medicines.

**ANTICHOLINERGICS** are taken regularly to help control the tightening of the airways known as "bronchospasm." They act as a "drying agent"

**COMBINATION MEDICINES** Sometimes there's a need to combine 2 different medicines in one dosage for the best effect. For instance a short acting Beta 2 and a anticholinergic.

**CORTICOSTEROIDS** help stabilize the lungs. They can be inhaled or taken in tablet form. They can also be given as injections or in liquid form for a nebulizer. They're anti-inflammatory which work over a period of time to help reduce cough and inflammation and help to make breathing easier.

**ORAL STEROIDS** (Tablet Form) slow down your adrenal gland and are often prescribed when you are having an exacerbation (a flare up) or a lung infection. It's very important to follow your Dr's instructions when taking this medicine.

**ANTIBIOTICS** are used to treat bacterial infections. Because your lungs are weakened you should contact your Dr at the first signs of an infection. A few signs to be aware of are increased cough, wheeze or shortness of breath, a change in mucus colour, consistency or amount, a fever or chills.

**OXYGEN** We all have the same addiction which we were born with. Oxygen. Sometimes you have to use supplemental oxygen for a short while (after an illness) or long term. Used with small nasal prongs or a mask, it's supplied via a oxygen tank (cylinder) or a concentrator.

**FLU & PNEUMONIA VACCINES** You should get an annual flu shot (usually in the fall). Pneumonia vaccines are needed only once though a booster is recommended every five - ten years.

*Remember:* YOU ARE NOT ALONE!

Together we **CAN!!....**

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Please fill in and mail, or go to the web address below for the on line form.

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Williamswood, NS B3V 1E6 Canada

The “On-Line” Membership Form can be found at http://www.copdcanada.ca/sign_up.htm

Contact Info: E Mail Contact@copdcanada.ca or Membership@copdcanada.ca

Our Main WebSite is www.copdcanada.ca

There’s no Dues or Fees. Membership is FREE.


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<td>Patient, Caregiver, Family Member/Friend,</td>
<td>Internet Search, Family/Friend, Pamphlet, Newsletter, Referral</td>
</tr>
<tr>
<td>Medical/Professional, Other (if other please specify)</td>
<td>Other (if other or by referral, please specify)</td>
</tr>
<tr>
<td>Do You have any Comments or Suggestions?</td>
<td>As a member of the Network it is understood and agreed that if we undertake a mail campaign to legislators or other governing bodies of importance as it relates to COPD, that you will participate in this when the request to members goes out. Usually the Maximum is twice a year. (The above is applicable to Canadian members)</td>
</tr>
</tbody>
</table>

Please Note: All information gathered/received will be held in the strictest of confidence and WILL NOT be shared with anyone at any time (with the exception of your name only if the event a supplier wants to verify your membership). Your personal information will NEVER be compromised.

Once we receive your application, a welcoming note will be sent to you with additional information along with your Membership Number, the most recent Monthly "Airmail" and Newsletter.

"Together" We CAN !!! Care, Advocate, Network