



NEWSLETTER 28

SPRING 2011

A welcome to all members of SILA, who have regularly used our pamphlet as a means of gathering information about their disease. We are now offering you this new format of newsletter which we hope you all will find accessible for keeping in touch with members life experiences and also developments concerning treatment of sarcoidosis. In this new format we detail the following:

CONTENTS

- ◆ Editorial
- ◆ Sarcoidosis Seminar
- ◆ A Medical School "Patient"
- ◆ My Years as an Evacuee
- ◆ Happiness is Catching
- ◆ Annual Meeting of American Chest Physicians
- ◆ SILA Noticeboard

Editor: Heather Walker Asst. Editors: Joe & Sue Gray

Dear SILA Supporter,

Once again I must apologise for the late arrival of the Newsletter, which is due to a number of reasons, but I hope it will be worth the wait. I had hoped for more Patients' stories, but have included a story of a SILA member's childhood, which was sent to me after an enquiry as to whether or not she could have been at risk from living for a while with someone who had TB. As yet, nobody knows how sarcoidosis is acquired and many members and others may have also been looking back into their past and wondering also.

I am still able to focus on the efforts made by SILA members and others to raise money for SILA. I did think that as mentioned in SILA newsletter No 27 that the proposed cycle from Land's End to John O'Groats would be one of the more challenging ventures, undertaken. Then I was given details from Gareth Mottram, a sarcoid patient, who is planning an expedition to Kyrgystan, a Central Asian State on the borders of China, where he is to attempt the first ascents of some of the Tien Shan mountains. Gareth included photographs from previous trips he has made and is hoping to raise awareness of sarcoidosis as well as raising money for SILA.

I have also received details from James Brumpton who, with five friends in April, is aiming to complete the Coast to Coast Cycle run from Whitehaven to Sunderland to raise money for SILA. I am sure that everyone will give these expeditions every sort of support.

The Rotary Club of Romsey raised money for SILA on the Rotary Walk the Test Way on Sunday 10th October 2010, for which SILA is very grateful to all who took part.

I have been sent details of a scheme run by Waitrose called Community Matters. Each month the branch will support local good causes by donating £1000 to the chosen charity. This may be helpful to anyone living near a branch of Waitrose who can fill in a form and who wants to nominate SILA.

I was pleased to agree to a request by the Wellcome Library, part of the Wellcome Trust, to participate in the UK Web Archiving programme for SILA's web-site. This programme comprises five leading UK institutions including the British Library and this will mean that SILA's web-site will be permanently accessible to future researchers.

I have been waiting for some time for a doctor to come along to talk to SILA about sarcoidosis then three have come along at once. On June 2nd 2011 in the Boardroom at King's College Hospital, Denmark Hill, Dr. Birring will be talking about the Sarcoid Multidisciplinary Clinic, and Dr. Patel will talk on research and Dr. Barry Gray will also attend with Tracey Fleming, Senior Chief Respiratory Physiologist. Time 7 pm to 8 pm. All are welcome.

A further £17,000 was donated by SILA in December 2010 to the Royal Free Hospital, London and details will be given, as has been given in past Newsletters, of the research work involved by RFH, when these become available

I hope that after a long hard winter the coming months will prove beneficial for everyone's health, when the weather improves.

Heather Walker
Editor

UCB Pharma Ltd., Slough
Sarcoidosis Seminar
Wednesday 6 October 2010
Joe Gray

UCB Pharma Limited is a global biopharma company with over 8000 employees, headquartered in Brussels, Belgium. It has a strong market presence in more than 40 countries, €3.1 billion in revenue (2009) and numerous strategic partnerships across the industry. The company's research and development headquarters are based in Slough, Berkshire.

UCB is researching a number of inflammatory diseases, including sarcoidosis, and are always looking for advocates for patients (not for a particular medicine) to come in to talk about their experiences with certain diseases. In the past they have had patients with osteoporosis, asthma, Crohn's disease and rheumatoid arthritis. They are not asked to assist internal UCB meetings in order to learn about or be induced to promote or defend a particular medicine. The company looks to learn from them and not to influence the patient in their role as a patients' voice.

When planning this seminar, UCB approached SILA for a volunteer to give an internal talk about their experiences with sarcoidosis which I did when contacted by Heather.

The seminar took place on Wednesday 6th October 2010 at Slough and was attended by some 70 UCB research staff. Dr Roly Foulkes, Vice President, Inflammation Research, opened the seminar and introduced the speakers.

Dr Toby Maher, Consultant Respiratory Physician, Royal Brompton Hospital, gave a presentation in which he covered all the clinical aspects of the disease. From a patient's point of view, I found his comments on chronic fatigue particularly interesting. In his view,

chronic fatigue in sarcoids is often under rated by the medical profession. He referred to a number of his patients who simply feel too tired to even get out of bed in the morning and then they are labelled lazy by people who lack understanding of this disease. More and more patients are being referred to the Brompton with chronic fatigue with no apparent cause. On investigation, a number have proved to have sarcoidosis. I explained this to my GP at a recent visit and he said that he would not routinely call for a chest X-ray of a patient with chronic fatigue when considering possible lines of investigation. Personally, I find chronic fatigue a problem. It is not unusual for me to have an overwhelming need to sleep for an hour or two in the afternoon or early evening and then sleep soundly through the night as well. If I have a heavy physical or mental concentration day I need to plan a lighter one the next day anticipating a feeling of intense fatigue.

I followed Dr Maher with a presentation from a patient's perspective. The presentation started with my personal background, employment history and environmental exposures. I then covered my symptoms and diagnoses from 1972 when I had an acute attack and again about 2004 when chronic sarcoidosis re-emerged. Next was a discussion of my reaction to diagnosis and current symptoms. I then explained my drug treatment regime since 2005 when I started on prednisolone and my continuous treatment to the present and the impact of the disease on my life in terms of work, family and leisure. Finally, I referred to the excellent medical care I have received from the Norfolk & Norwich University Hospital, GP and respiratory nurses on a pulmonary rehabilitation course. Also, my role as a 'patient' for the students at the hospital medical school where you have the opportunity to raise awareness of the disease from an early stage of their careers.

I have had psoriasis for some 45 years and the question arose as to whether there is an association between the two diseases. Dr Maher commented that he has half a dozen patients with both but that

hardly constitutes a statistically valid sample!

Using this presentation as a starting point, I have written other articles for the Newsletter in the Patients' Stories series and my experiences as a 'patient' for medical students

My wife, Sue, accompanied me to the seminar and we would like to thank UCB Pharma Limited for the very generous reception we received and for making a donation of £500 to SILA by way of an honorarium for the presentation.

A Medical School 'Patient'

Joe Gray

Let's face it, doctors have to learn their skills somewhere and somehow but who's willing to let student doctors loose on real live people? The answer, your local medical school! Being a 'patient' for medical students can provide an entertaining afternoon and provide an opportunity to put a little back into the system.

Some months ago at a Breathe Easy Norwich meeting one of the Specialist Respiratory Nurses asked if I'd be willing to be a 'patient' for some respiratory medicine teaching sessions at the Norfolk & Norwich Teaching Hospital. The Medical School provides free parking at the hospital, a couple of cups of coffee or tea and £5 expenses per session. The sessions last three hours, during which you will be examined by 3 or 4 groups of students, usually about 6-8 at a time, under the supervision of a consultant or registrar. Please note that I am retired and available during the week.

The students are not allowed to do anything invasive but do take a medical history, listen to your chest and take your pulse, etc. Generally, the students do not have access to your medical notes, X-rays or results of your lung function tests before they examine you.

Unless I've got breathless from some physical exertion, I appear to be entirely normal. If they listen to my chest with a stethoscope or tap my chest I, again, appear to be entirely well which they find disconcerting and when they volunteer a diagnosis their guesses can be quite far ranging! Occasionally, one asks point blank what's wrong with me and I usually say you're supposed to tell me! You also learn some interesting snippets yourself. Often the students look for a pulse in the jugular vein in the neck which is usually not very prominent in my case. However, if you press my liver fairly firmly this pulse becomes much more obvious through a reflex.

As a 'patient' in the Medical School, you not only learn quite a lot about your disease but you also meet all the consultants and registrars of the Respiratory Medicine Department involved in teaching and get to know them a little better. All of them at Norwich use an effective discovery style of teaching and are very relaxed and enthusiastic with the students.

Medical Schools are usually in need of more 'patients' for teaching sessions and I strongly recommend volunteering for what is a worthwhile activity for everyone involved.

My Years as an Evacuee

Jean Chase-Long

I was seven years old when war was declared, my mother and our neighbour were discussing it over the garden fence and the name 'Hitler' was spoken of. A few days later I was playing in the road with my favourite doll Greta and pram, when the very first siren sounded. I was absolutely petrified and ran into the house crying, 'Hitler's coming'. The elderly couple, Mr & Mrs Manvell, who lived next door, came into our house and we all took cover in the pantry which was very small. I would not eat my favourite dinner of mince because I expected Hitler to appear any moment. My mother was upset too and after cooking dinner none of us wanted any.

My Mum and Dad decided after much thought and discussion it would be safer and wiser for me to go and stay with a relative of my Grandma who lived in Somerset as the raids were now very frequent, mostly every night. So with my gas mask and label pinned to my coat we caught the train to Wellington in Somerset. I had no idea that I would be leaving my parents for five years and just thought I was going on holiday.

My Grandma's relatives were Mr and Mrs Stevens, the people (Aunty Flo and Uncle Joe), that would be caring for me. When Mum and I arrived we were greeted warmly by a little round, plump lady (Aunty Flo), in a spotless white apron and she showed us into the parlour. At this point I vividly remember saying in a loud voice, 'Isn't she fat, Mum'. My mother gave me a strict telling off for being so rude and would probably have smacked me on the legs if we had been at home.

Aunty Flo was a brilliant cook and house keeper and she offered my mother a glass of homemade wine and after the second glass I wondered why they were so giggly, now I realize why. After our meal we retired to bed.

The following day or maybe a few days later I met the girl next door called Janet Ferris who was the same age as me. She invited me to see her rabbits and we became firm friends. When I returned my mother had gone as she couldn't bear to say good-bye as she knew we would both be upset at being parted and at the back of her mind she wondered if she would ever see me again. Being a mother myself I can imagine how devastated she must have felt returning to Portsmouth alone.

The raids on Portsmouth were night after night. I had no idea how many years I would be parted from my parents. I just thought I was on holiday.

Aunt Flo and Uncle Joe had no children so I was completely spoilt, they were simple country folk. Aunt Flo worked in the Vicarage which seemed a very large house to me or it may have seemed large to me because I was small. The grounds were a child's paradise. School which I vaguely remember was good (as far as schools go) and the other children were kind to me because I was that poor evacuee from Portsmouth. One thing that sticks in my thoughts was I would go to the swings swinging to and fro and saying to myself when I open my eyes my much loved mother will be standing there but she never was. Children in those days could safely play anywhere. My friend Janet (from next door) would play marbles in the gutter and whip and top. We were very close friends, such an innocent childhood.

In Wellington, Somerset very rarely did we have any air-raids but occasionally the German planes would unload their bombs on returning to base and we would hide under the big wooden kitchen table, I cannot ever remember seeing air-raid shelters.

My Mum used to visit me when she could but I cannot remember how many times as it's a long time ago and at 75 years old my memory isn't so good. I vividly remember it was heart-breaking when she would leave and it took us both days to adjust to the separation

Flo and Joe Stevens were so very kind folk and looked on me as their child. I could not have wished for better people. Every Sunday we walked to Church and my reward was a sweet, they were on ration.

During the week we would go into the woods to collect firewood for the winter, putting it in large sacks and then sit on a log and eat lettuce sandwiches. The lettuces were grown by Uncle Joe. I can still remember the lovely taste of fresh lettuce. In the woods I would hear a skylark sing and even today when I hear one it brings back memories of me sitting on a log eating my lettuce sandwiches. Another memory of those days is the smell of honeysuckle or when I see a Beano or Dandy Comic. I can just see myself lying in bed reading the comics with the perfume of the honeysuckle wafting into my bedroom.

After 5 years, aged 12, my days at Wellington were coming to an end. My beloved Uncle Joe contracted TB and for my own safety it was decided I should return home. I shall never know how these lovely simple folk coped with it and the fact I was leaving them. I was the apple of their eye. We wrote to each other occasionally and although Aunt Flo was a brilliant cook and housekeeper, letter writing was difficult for her. I too found letter writing a chore.

Years after the dreadful war was over I felt I wanted to get in touch with Aunt Flo and Uncle Joe but we had lost the address. However, fate took a hand. I went on a coach trip and got talking to a lady that was staying in Portsmouth and she came from Wellington in Somerset. I told her I was evacuated there during the war but had lost all contact with Mr & Mrs Stevens. As it was a small village this kind person said she would try and find out if they were still alive and I never expected to hear from her. She kept her word and eventually I had a letter saying they were buried in the Church next to the Vicarage where Aunt Flo worked and were I played for many hours. I wished I had written more to them, such a lovely couple.

Happiness is Catching

There is an article in the 15 January 2011 issue of New Scientist which does not mention sarcoidosis, but does throw much light on the disease sarcoidosis, which almost everyone agrees is likely to be some sort of immune malfunction disease. The title of the article is Happiness is Catching. Its essence is that considerable evidence is now available to show that the blood-brain barrier (effected by tighter cell walls of the blood capillaries) is far from perfect, with the result that antibodies from the immune system can interact with the brain by locking on to some of its receptors. Several studies with animals add to the evidence for this, but the two most striking cases are with humans. The first is a single case study but nevertheless compelling. A child, Sammy, developed perfectly normally until the age of 12, then suddenly started to exhibit such extreme Obsessive Compulsive Disorder symptoms that within a few weeks he was totally dysfunctional. A friend suggested that he should be tested for streptococcus, a common childhood infection, though normally producing only physical symptoms. The infection was found to be present and treatment with antibiotics commenced. The article reports that, Within a few weeks he was playing board games with his brothers. After six months of treatment, I knew that he would recover, says Beth [his mother]. Sammy remained on antibiotics for four years, as every time the dose was reduced he had a relapse. Now aged 20, Sammy has none of the compulsions that blighted his youth. The normal course of antibiotic treatment is about a week, so what is striking there is the need for treatment to continue for four years. Yet it chimes with the fact that the successful 12 person trial of Bachelez et al, in treating skin sarcoidosis with tetracyclines, continued the treatment for two years. It also chimes with the fact that the Marshall Protocol does achieve at least some success with long-term antibiotic treatment. The other striking case arose from a trial attempt to activate the immune system of terminally ill lung-cancer patients by stimulation of their immune system via an injection of the harmless bacterium mycobacterium vaccae. The trial was double-

blind, but it soon became apparent to the doctors which group was actually receiving the bacteria because of their improved attitude, demeanour and general impression of well being. The explanation for this is that the antibodies stimulated by the bacteria got through the blood-brain barrier and locked onto various receptors in the brain (unfortunately success with the main aim, to deal with the cancer, was not evident).

The evidence is only in mice as yet, but it has been shown with them that immune cells can impair memory. Also it has been shown (the article did not reveal how) that antibodies associated with the autoimmune disease lupus can get into the brain and kill neurons. This suggests a reason for the memory problems of lupus patients. If immune cells can get into the brain this way and produce these various effects, it provides a ready explanation for the extreme fatigue, brain fog and memory problems experienced by many sarcoidosis patients. I have rushed to let people know about this article, as a copy of it, on pages 30-33 of the 15th January issue, may be just the thing to hand to your doctor if he or she is sceptical about the relevance of mental problems to sarcoidosis, or even the existence of such problems.

From the Annual Meeting of the American College of Chest Physicians

Vancouver, B.C. – Contemporary management of pulmonary sarcoidosis is moving away from hard clinical targets and toward patients' self-reported well-being and goals, according to Dr. Daniel A. Culver, a pulmonologist at the Cleveland Clinic. Physicians may treat sarcoidosis for a variety of reasons, and research is helping to sort out which of them are valid, he said at the annual meeting of the American College of Chest Physicians. One reason might be to improve radiographic or physiologic parameters. In particular, the Scadding stage of a patient's chest X-ray at presentation has been used for about 50 years to estimate prognosis and the need for treatment. "But in fact there are a number of pieces of data coming out now that suggest that the chest X-ray may not be the most ideal way to measure how things are going to go for patients," he commented. In one study, for example, half of patients with pulmonary sarcoidosis were rated as having a better chest X-ray during an exacerbation as compared with before, despite their worsening symptoms and spirometry (*Respirology* 2008; 13:97-102). Another reason for undertaking treatment might be to improve patients' symptoms, according to Dr. Culver. In this regard, a recent review has described a so-called sarcoidosis penumbra, a collection of disease-related issues that affect patients' well-being but are often not well captured by tests physicians rely on (*Semin. Respir. Crit. Care Med.* 2010; 31:501-18). For instance, two in every three patients have depression, and one in six has sleep apnoea. "This took us a long time as sarcoidologists to recognize, that it's not the X-ray and vital capacity that the patients care about," but rather their daily ability to function and enjoy life, he commented." To optimally treat sarcoidosis, one of the new things we are discovering is that we need to ask the patients the questions that get to these sorts of issues and target our treatment to these sorts of issues," Dr. Culver said. "Going forward ... for both immunosuppressive therapy and the treatment of sarcoidosis in general, we are going to see it more focussed on patient-centred outcomes and quality of life rather than things that

we'd all like to measure, like the vital capacity." Another reason that physicians may treat sarcoidosis is to alter the natural history of the disease and prevent fibrosis. But "most sarcoidosis will resolve within the first 5 years, at least radiologically," Dr. Culver noted, and current evidence suggests treatment does little to alter this trajectory. In one study, 39% of patients with stage 2 or 3 disease on chest X-ray had neither progression nor improvement during a 6-month period. When these stable patients were assigned either to immediate treatment with a fairly aggressive regimen of prednisolone or to as-needed treatment only if spirometry showed deterioration, just 19% of the latter group required treatment during the next 5 years (Thorax 1996; 51:238-47). "If you can hold off on treating, you may be able to prevent side effects from medicines ... and still have a patient who has their disease spontaneously resolve," he commented. That said, the as-needed treatment group had a smaller improvement in forced vital capacity (FVC), and there were some other potentially important differences in outcomes between groups. "Suffice it to say that right now, we don't think that steroid therapy given pre-emptively has a tremendous impact on the natural history of the disease," Dr. Culver commented. "This is probably the best study that addresses this question, but this doesn't necessarily resolve the issue. "Finally, physicians may initiate treatment for sarcoidosis because they feel compelled to do something, according to Dr. Culver."It makes us feel better when we go home at night: We have done something for the patient who came to see us," he commented. "But the evidence for this [practice] really is not very strong, despite the fact that steroids have been used for about 60 years now." A recently proposed algorithm for treating pulmonary sarcoidosis draws on all of these accumulated data and recommends symptom assessment as a first step (Semin. Respir. Crit. Care Med. 2010; 31:501-18)."If the symptoms are relatively mild or modest – and this requires a discussion with the patient – then I think observation is completely reasonable," Dr. Culver said. In more severe cases, the algorithm proposes short-course, moderate-dose therapy with prednisone 20-30 mg daily for 3-4 weeks, as supported by sev-

eral studies, including a recent one among patients with acute exacerbations (Am. J. Med. Sci. 2010; 339:1-4). In other words, "be less aggressive with your steroid dosing," he recommended. "You can really get away with shorter courses, with lower doses than we have been using in the past." For patients who have a good response, the goal is to taper to 10 mg daily or less, a practice endorsed by a Delphi consensus study of sarcoidosis management (Respir. Med. 2010; 104:717-23). "That's evolving as an important target for long-term management of sarcoidosis patients," he noted, and it also helps minimize steroid adverse effects. When patients have an inadequate response to prednisone or are unable to reduce the dosage to 10 mg daily, the algorithm suggests adding an immune modulator (methotrexate, azathioprine, leflunomide, or mycophenolate) to therapy. "The choice of immune modulators ... is really dealer's choice," Dr. Culver commented. "Suffice it to say that it's most important that you become comfortable with something and you are used to how to use it, more so than necessarily exactly which one to use. "There have been few head-to-head comparisons of these agents, although methotrexate is by far the agent preferred by U.S. physicians treating sarcoidosis, partly because it has been the best studied. "That's the drug that we use as our second-line agent," he noted. "The reason that we like methotrexate is it seems to work pretty well, it's pretty inexpensive and pretty reliable, and it's not hard to get through the insurance company." "Data from his institution show that leflunomide also works well. A review of 40 patients with pulmonary sarcoidosis found they had an improvement in FVC within 6 months of starting this drug (P = 0.01), as well as a reduction in the average prednisone dose to 5 mg daily. "So we have really moved leflunomide to the next agent in our algorithm after methotrexate," he said. V Infliximab is the only agent that has been shown to be efficacious in a double-blind, randomized controlled trial of patients with sarcoidosis, according to Dr. Culver. In unselected patients, Infliximab is associated with just a 2.5% improvement in percent predicted FVC (Clin. Chest Med. 2008; 29:533-48, ix-x) – or about that seen with steroids.

But among the subset having more severe lung disease, with an FVC of less than 69%, there is a roughly 3.25% improvement. The improvement was 6% in the randomized trial (Sarcoidosis Vasc. Diffuse Lung Dis. 2006; 23:201-8). "So, in fact, we think for patients failing cytotoxic agents that Infliximab is a nice option," Dr. Culver commented. And studies are helping to identify which patients are most likely to benefit from Infliximab: those who have had disease for more than 2 years, have worse dyspnoea (a Medical Research Council dyspnoea score of at least 2), lower FVC, poorer quality of life (assessed with the St. George's Respiratory Questionnaire), reticulonodular changes on their chest X-ray, or an elevated C-reactive protein level. "In fact, these are some of the same entry criteria that are being used for the current trial of biologics in sarcoidosis, trying to target that more severe patient population," he noted. In concluding, Dr. Culver advised physicians to establish and keep in mind the goals of treatment, and to remember the chronic nature of sarcoidosis. "If I can leave you with one thing, the message is ... you have to sit and talk to your patient and find out what's important to them, what do they want to accomplish," he said. "That's the best thing that you can do as you think about treating your patient longitudinally, because remember, you are not treating this as if it's an infection, you are treating this as if it's hypertension that needs to be controlled in the long term." Dr. Culver reported having affiliations with the biotechnology and pharmaceutical companies Centocor (manufacturer of Infliximab), Takeda and Actelion.

SILA Noticeboard

New web-site for those with fluctuating chronic conditions who want to stay in work. More information at www.yourworkhealth.com. Started by employment organisations, healthcare professionals and Department of Work and Pensions(DWP). Support for employees with their rights and the law and who can help .Critical Illness Insurance, etc.

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European Medicines Agency, 7 Westferry Circus, Canary Wharf, London E14 4HB, 020 7418 8427, www.ema.europa.eu released the following information in March 2011: EU Clinical Trials Register goes live. Public online register gives access to information on clinical trials in the 27 EU Member States at <https://www.clinicaltrialsregister.eu>.

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The European Lung Foundation (ELF) was founded by European Respiratory Society (ERS). For more information: ELF, 442 Glossop Road, Sheffield, S10 2PX, Telephone: 0114 267 2875 www.european-lung-foundation.org This web-site gives useful information including leaflets on sarcoidosis in English and other languages. E-mail: Anne-Marie.Wish.org.uk

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Web-site for those with Uveitis and Iritis at www.oliviasvision.org. Useful information on treatment, research, resources and personal stories.

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Sponsorship Forms

SILA can supply Sponsorship Forms for members and others participating in events.

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Information Received

Haemochromatosis common genetic disorder symptoms may include chronic fatigue, joint pain Simple blood test will detect. The Haemochromatosis Society, Hollybush House, Hadley Green Road, Barnet, Herts.,EN5 5PR www.haemochromatosis.org.uk Telephone: 020 8449 1363

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Orpington: Anyone in the area who would be willing to give a lift to a SILA Support meeting, please contact at lesleyronson@hotmail.com

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SILA AGM will be held on 6th October 2011 at 7 pm in the Boardroom, King's College Hospital, Denmark Hill, London, SE5 9RS.

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Electronic Version of the SILA Newsletter

The SILA Newsletter is placed on the Social Network site (<http://sarcoidosis.ning.com>) in Word format – in the Topic in Main Forum titled Publication of the SILA Newsletter – before being sent out as hard copy. To access this, you need to join the Social Network. At about the same time, an easily accessed pdf copy will be put on the SILA website (along with other back numbers). This may reduce paper use since some people are perfectly happy with an electronic version; please let me, Heather Walker, know if you do not wish to receive the hard copy version.

Annual Subscription

Still £12 per annum. SILA welcomes comments and contributions to the SILA Newsletter; also fund raising ideas or initiatives.

Support Meetings

Meetings are held at King's College on the first Thursday of each month except in August when there is no meeting. Enquire at the KCH Help Desk for the location of the meeting (usually the Boardroom). Meetings are held between 7 and 9 pm. Details of how to reach KCH are on SILA's website.

SILA West Midlands Branch

This branch is run by SILA member Mrs Carol Bashford, 38 Yew Croft Avenue, Harborne, Birmingham, B17 9TR. Contact Carol: 0121 427 5462 or e-mail her at carol_bashford@hotmail.com for information about any future support meetings, help or advice.

The Irish Sarcoidosis Support Group

ISARC is at www.isarc.ie. E-mail: info@sarc.ie.
Mary Walters is Chair of ISARC, telephone number 01903 872416.

Mailing Address

SILA (Sarcoidosis & interstitial Lung Association)
c/o Department of Respiratory Medicine
1st Floor, Cheyne Wing
King's College Hospital
London SE5 9RS.

Our Web Address

SILA's sole web address is now www.sila.org.uk; the e-mail address is heather@sila.org.uk.

Contributors

Thanks are due to Andrew Ferguson for sending in the following:

- ◆ Happiness is Catching
- ◆ Abstract from the Annual Meeting of American Chest Physicians

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