Price £ 4.00 (Free to members)

Pathways

The newsletter of Leger ME/CFS Supporting Myalgic Encephalopathy or Encephalomyelitis (ME), Chronic Fatigue Syndrome (CFS), Post Viral Fatigue Syndrome (PVFS), Fibromyalgia Syndrome (FMS), Patients & Carers.

Welcome to Pathways No. 62. (Winter 2019)

You Write In

Bill Writes: I've managed to stop smoking, but I'm vaping with using e-cigarettes. I have read in the paper about deaths in the USA. and some companies stopping selling vaping products. How safe is vaping and has anyone had any problems with this in the UK?

****** Well done for getting off cigarettes. Keep up the good work! ******

Vaping is safer than cigarettes, but it still carries a risk, which I understand is about 5% of a cigarettes. The problem with cigarettes is the toxic bi products e.g. tar, carbon monoxide and other combustion products these produce. With vaping, it is much cleaner, and the risk depends on the vaping fluids or solutions. Some are just a nicotine solution which give the same buzz as cigarettes. The problems are that there is no control about who makes vaping fluids, and no recognised standards.

The residual dangers of vaping are mainly due to the nicotine content in the UK.

Vaping-related lung injury was first reported in the US, where there have now been 2051 cases and 39 deaths. Researchers there say most cases are connected to use of products containing THC, the main psychoactive molecule in cannabis. It is believed the lung injury may be caused by a reaction to vitamin E acetate an ingredient in some vaping liquids which is not permitted in e-cigarettes in the UK. US researchers found the additive in all 29 samples of lung fluid they tested from affected patients. The UK teenager that developed intractable respiratory failure is now in recovery following life-saving treatment with extracorporeal membrane oxygenation. This is the only confirmed case of vaping-associated lung injury to be recorded in the U.K.

However, Public Health England (PHE) has reiterated its advice that vaping is 95% safer than smoking. Smoking kills half of lifelong smokers and accounts for almost 78,000 smoking related deaths in the UK every year. In absolute terms the risk is extremely small and, crucially, far smaller than that of smoking. The advice remains the same: if you smoke, switch to vaping; if you don't smoke, don't vaper.'

At Leger ME meetings held in the Redmond Centre, they a smoke free and vaping free.

Nicola Writes: I received the message about the October Meeting on depression and ME. Is there any way information can be shared on the Leger ME Facebook pages for those that can't make it. What do you think?

I'm sorry Nichola, but the answer is `No` for the following reasons:-

1). A lot of material used is either copyright, sensitive and/or could be easily taken out of context.
2). Peoples personal experiences and contributions are discussed at Group Meetings. These are confidential and not for the Facebook pages or anyone else outside the meeting.
3). Condensed, made anonymous and contexed content from Group Meetings is always included in the Pathways Newsletters.

If you cannot get to a meeting, sometimes depending on the content, handouts from the meetings are available. Just email us and ask when you get a meeting notice. We'll do our best to help.

Tim Writes: I have ME/CFS, grade 4 very severe, but also, I need a hip replacement. My surgeon at DRI is quite happy to do it, but my Infectious Diseases Consultant in Sheffield says definately not. Have you any idea why he is blocking this?

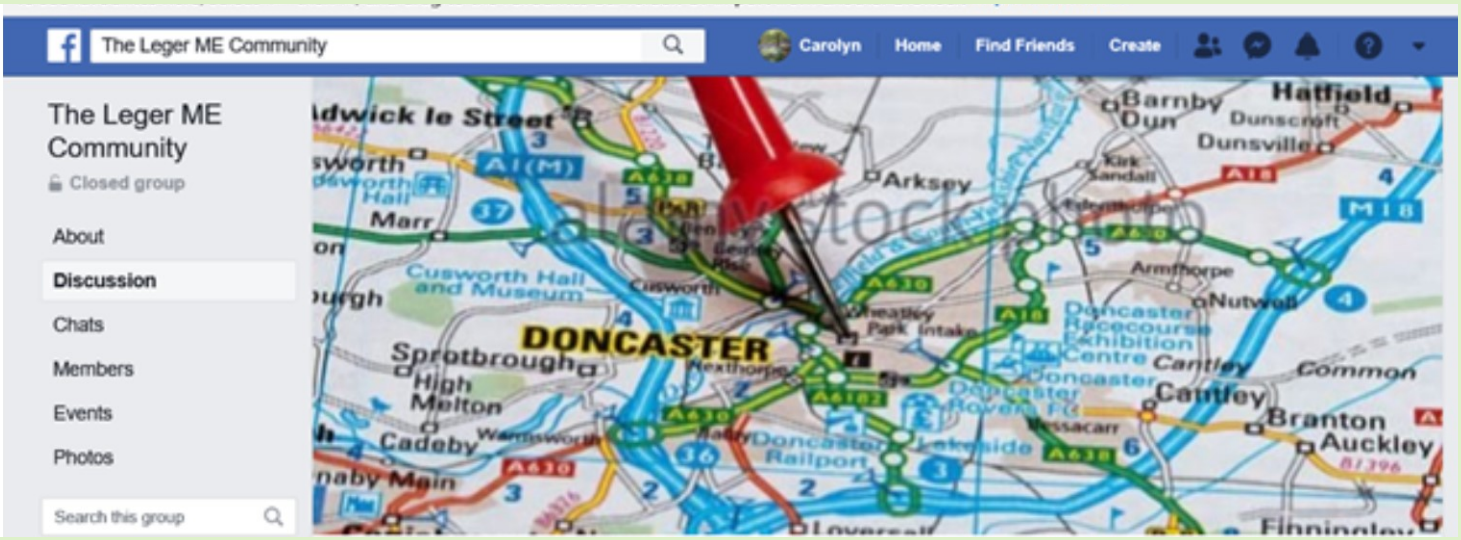
I recently attended 'Joint School' with a group member due for a hip replacement. The first thing the nurse emphasised was to understand is that a replacement joint will never ever be as good at the

original. Hip replacements are on the NHS in this area mainly for pain relief more than anything else. Prosthetic joints are mechanical and contain no blood vessels. One of the biggest problems with replacement joints are infections. Antibiotics just can't penetrate them, so if they get infected, they form a septic focus. To treat an infected replacement joint takes many weeks and at least two follow up operations. When you do have a joint replacement the first thing you will encounter is a complete body flora clean-up. You will be swabbed and checked for MRSA, an infection for which normal antibiotics are useless. You will have to shower and cover yourself with an antiseptic body wash every day for a week before surgery. The operation itself is simple enough. You will be in hospital for about a week then, sent home. You will need help even for the most basic things like going to the toilet and washing. You will be on crutches at first for a few weeks, then hopefully gradually recover as the new joint beds in.

The Christmas tree in Brodsworth Hall, Doncaster with thanks to English Heritage

The biggest danger is immune activation. Perhaps your infectious disease consultant is not satisfied that you could cope with such a traumatic operation, the work up and after care and that you may easily get an infection. Apart from this, other issues like a significant post operative falls risk, and a hyperactive immune system which may react to or reject the new joint. Even something as simple as an insect bite or sting on the days before the operation could result in an unacceptable risk and the operation would be cancelled. One of our members was all set to have a knee replacement when the found out she was sensitive to the joint materials. At the same time, she was also found to have a condition which could have killed her, if not urgently treated. One of our other members recently had a successful joint replacement. She carried out the hospital instructions to the letter regarding infection control workup. Although she was able to use a walking aid after eight weeks, it has taken about a year to fully adapt. There have been no major complications. I'm sure there will come a time when your infections disease consultant will give the all clear at some future date.

Leger ME Community Facebook Group



The Leger ME Community Facebook page.

Is anyone housebound or feeling isolated or lonely? Please don't feel alone in this group. There are people to chat to on our Facebook page. Come and join us in the newly launched Facebook group that is exclusively for our members.

Those that have already joined are chatty and friendly and it is proving a great place to get to know new people give and gain support, enjoy their humour, gossip and company. To enrol, all you need to do is search on Facebook for **The Leger ME Community**

You will be asked three very short questions before joining just to check that you are a fully paid up member. If you have any problems with Facebook then please do not hesitate to contact me, Nichola, at **njstockton@talktalk.net** . Looking forward to seeing you there!

Common Issues Concerning ME/CFS and those 'NOT IN THE KNOW'

Christmas is a time when families get together, and common ME/CFS issues cause much misunderstanding problems for relatives or those in authority.

Here is a short resume:-.

1) ME /CFS is used to describe of number of diseases known as fatigue syndromes. Myalgic Encephalopathy or Encephalomyelitis (ME), Chronic Fatigue Syndrome (CFS), Post Viral Fatigue Syndrome (PVFS), & Fibromyalgia Syndrome (FMS). These are recognised by the NHS and NIHCE.

2) Medical research shows reduced blood flow in certain areas of the brain, with hormonal and immune system changes. As a consequence, there are mental and physical aspects to the syndrome Some patients are very debilitated. There is no cure or specific diagnostic test.

3) To the untrained eye patients will ME/CFS will appear to be normal and healthy. The best cases are able to live a near normal life; the worst are in bed 24 hours a day. Most cases are somewhere in between. All ages are affected 5 –85.

4) Patients with M.E. describe it as 'suddenly becoming 85' or 'being stuck in 1st gear'. What may be a normal task so someone is like a full day's work to a patient!

5) Mental health issues include poor short-term memory, slurring and Nominal Aphasia. Aphasia is when someone can't find to right word, may stammer or say the wrong word, not realising they have done so. This is a fatigue effect which can have implications when interviewing patients, especially under pressure. This problem resolves on rest, usually after 24 hours.

6) Patients with fatigue syndromes usually have sleep disturbances, and may need to sleep at abnormal times, especially during the day. Most will be on drugs to control symptoms, usually painkillers and antidepressants. Controlled drugs are sometimes prescribed.

7) Making a patient stand or walk a short distance may bring on a relapse, which can leave some housebound, or bedbound, from which recovery may take days to weeks. Most patients are aware of their limitations and know what they are capable of doing. Any pressure on patients to exceed their limitations could be regarded as causing harm. The level of disabilities is equivariant to COPD plus congestive heart failure.

8) Some M.E. patients can react adversely to smoke and fumes. This includes perfume and toiletries, petrol and household cleaners. This is usually a sign of Mast Cell Activation abnormality and may lead to anaphylaxis or angio-oedema, both of which are clinical emergencies.

9) Some patients have a complication known as gut fermentation (auto brewery syndrome). Ingestion of sugars in food results in alcohol appearing in a patient's blood. In a typical case a teaspoonful of sugar will produce a blood level of 5 mg/100ml after one hour. This may be of significance in drink/ drive cases where the law assumes blood alcohol is from intoxicating liquor. Patients may not be aware of this issue. The problem can be treated with a special diet, or antibiotics.

10) Generally, DVLC allow ME/CFS patients to keep their private car licenses but will be excluded from HGV/PSV. Many can only drive 10 – 20 miles with full concentration. Automatic gearboxes or controls adoption can help. Some can only safely drive at certain times of the day.

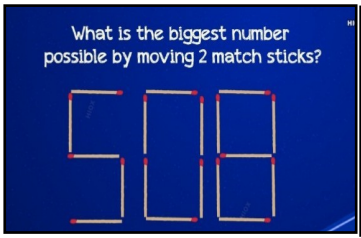
11) The main cause of death with ME/CFS patients is suicide, followed by accidents. About half of CFS/ME patients have other serious medical conditions which can be life threatening if mismanaged. About one third of patients have clinical depression.

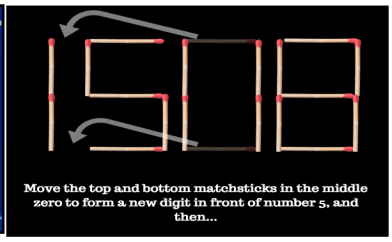
12) In some cases where children have taken much time off school, Social Services have totally misunderstood M.E., and some doctors have mistaken ME/CFS for 'Munchhausen by Proxy'. This has caused much distress to some families where children are involved.

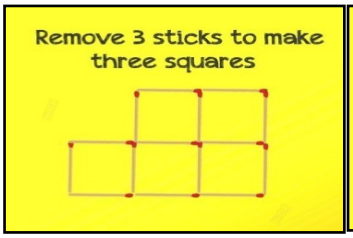
Puzzle Corner *By Nichola Stockton*

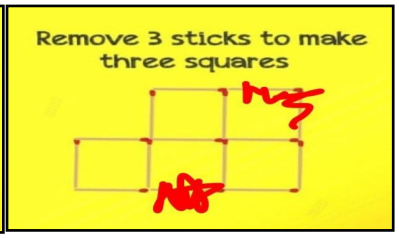
Over the past few months I've posted puzzles on the Leger ME Facebook Pages. I though it would be something different for Pathways.

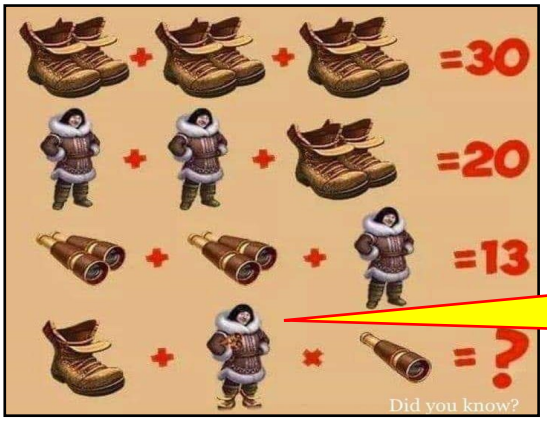
Here are the solutions to the last issue :











6 boots = 30 so 1 boot = 5

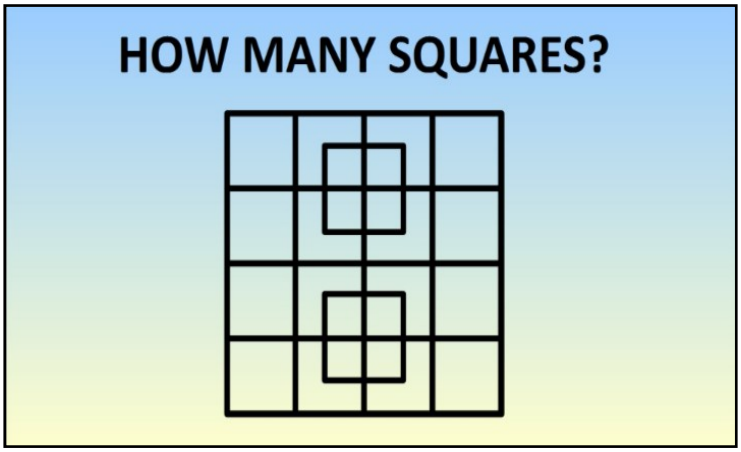
2 men + 2 boots =20 so 1 man = 5

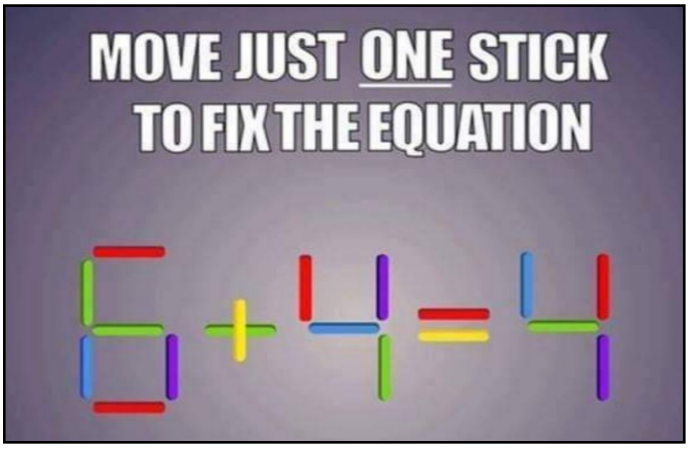
4 telescopes + 1 man =13 so telescope =2

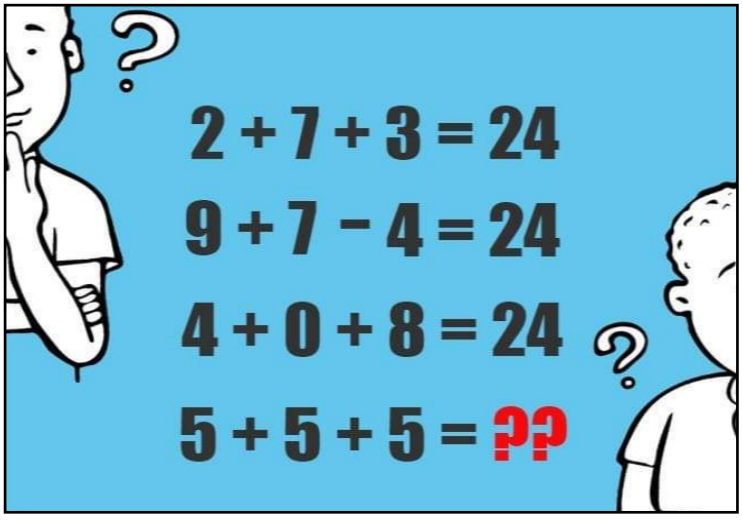
The tricky bit here was to spot that the man in the last line had two telescopes (or a pair of binoculars) under his arm, and a pair of boots on.

So 5 + (5+10+4) x 2 = 5+19 x 2 = 5 +38 = **43 answer.**

Here are some more puzzles







Please send your answer to me via the Facebook pages, and I'll publish the solution in the next Pathways.

Medicines Shortages *(November 2019)*

Last month, the government banned the export of all Hormone Replacement Therapy treatments, used to counter the distressing effects of the menopause, amid reports that women struggling with the condition were having to source supplies abroad. A 24-page document circulated to doctors last week from the medicine supply team at the Department of Health and Social Care. It reveals the NHS is running short of dozens of life-saving medicines - including treatments for cancer, heart conditions, Parkinson's Disease and mental health problems. Patients with epilepsy, are among the worst affected. Many patients are unable to obtain their usual prescription, and their frustration is compounded by not knowing why the usual medication is unavailable, beyond vague reports of a "manufacturing problem."

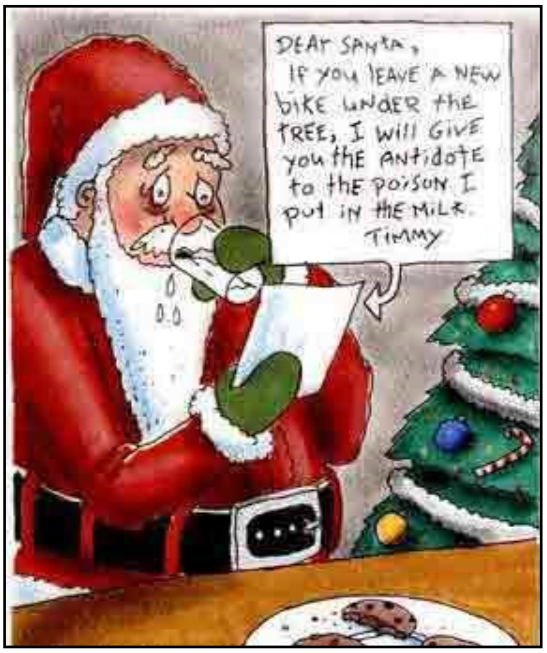
The Department of Health (DOH) and Social Care says it understands the concerns around availability of medicines and is "doing everything it can to ensure patients have access to safe and effective treatments. The DOH works closely with partners and industry to help prevent shortages and resolve any issues as soon as possible."

If the case of a well-known epilepsy drug the company which makes it for the UK license holder had production difficulties arising from a new packaging directive designed to prevent fake medication entering the UK market. This is an example of how the global supply chain of the modern pharmaceutical industry, where manufacturing and the acquisition of raw materials is spread around the world, has become ever more susceptible to disruption.

It's not only the UK that's affected. Shortages have also been reported in the United States and in a number of European countries including Poland, Denmark and Germany. The upside to the globalisation is that it's helped drive down the price of drugs, especially in the UK, where the NHS can take advantage of its bulk purchasing power. The Healthcare Distribution Association, which represents the main UK wholesalers, is planning to start distribution of a leaflet next month to all 16,000 UK pharmacists, explaining the myriad factors in the supply chain. It lists many of the potential problems which can have an impact on the supply chain, including IT failure, stockpiling of drugs by speculators, changes in regulation and sudden outbreaks of disease.

For many people with chronic problems this is concerning. I can remember having a conversation with a lady many years ago. The manufacturers of a common medicine used to control epilepsy changed the presentation of the capsule from a blue band around the centre of the capsule to being white and orange. The inside of the capsule, the active ingredients and excipients were unchanged. The lady in question was an epileptic, who had been seizure free for long enough to have her driving license restored. If she has a single epileptic seizure, her driving license would be revoked. The change in appearance was enough for her to lose confidence in her treatment.

There are some medicines for example lithium-based products where substituting another brand could cause toxic reactions. Lithium has a very narrow therapeutic index, and the difference between the effective dose and toxic dose is very narrow. To a product from company A of x milligram strength is not equivariant to the x mg strength product from company B. Different companies use different formulation for the same product. The difference is not the active ingredients but, in the excipients, which are required for the manufacturing process. Many people with ME/CFS are sensitive to certain excipients, which may be use dby one manufacturer product but not another in the equivalent product.



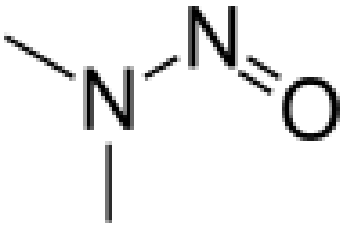
One of the major difficulties is that because medicines are expensive, there is a criminal temptation for fake products to appear. The packaging regulations are changing to take account of this. So in the future we may see security features on medicines packages like is those for credit cards or currency such as holograms, see through blister packs or metal strips.

More on General Medicines Shortages.

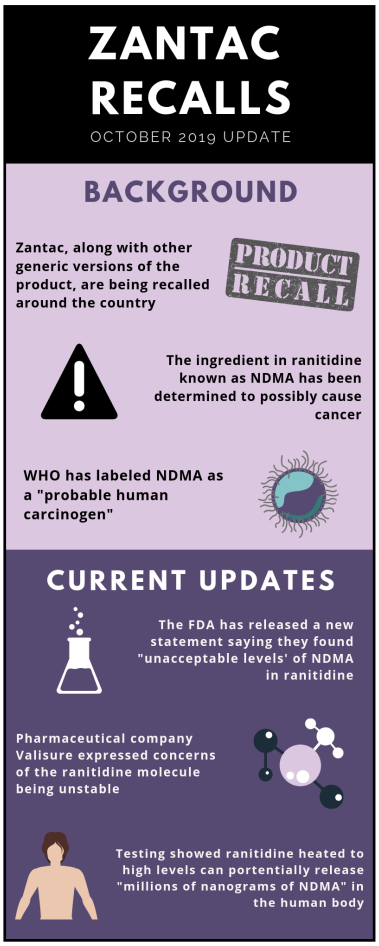
Due to supply problems doctors are considering unlicensed alternatives and to prioritise supplies of certain medications and to consider switching patients to unlicensed alternatives in some cases, as more than 100 drugs remain out of stock. According to MIMS (Medical Information Monthly, a doctor's magazine) a total of 103 medicines are currently unavailable. Many are not expected to be available until the new year. Strategies include prioritising the neediest patients for treatment, switching patients to alternative (in some cases, unlicensed) medications, breaking tablets in half, or referring to secondary care specialists for advice. An licensed medicine is one that has a product license to treat a specific condition, this has a product license (PL) number on the labels and literature. An unlicensed medicine is one that does not have a product license for to treat a specific condition. For example, low dosage (10mg) amitriptyline is not licensed to treat pain but is commonly prescribed for this application. Some relevant shortages also include medicines used by Leger ME members including Seroxat (paroxetine), mianserin and some types of fluoxetine. The government has recently activated a 'serious shortage protocol'fluoxetine, allowing pharmacists to supply an alternative strength or pharmaceutical form of the antidepressant without needing to go back to the prescriber. In order to mitigate the medicines shortages the government recently banned exporting of certain products, including, adrenaline auto-injectors (for emergency allergy treatment) and hepatitis B vaccines, to safeguard stocks for patients.

The case of Ranitidine shortage.

Ranitidine is currently in short supply after several manufacturers recalled their products because of concerns of contamination with a potential carcinogen. This started several months ago in the USA and has now crossed the Atlantic to the UK. The MHRA has issued an alert to healthcare professionals, as GlaxoSmithKline is recalling all unexpired stock of four types of Zantac (their trade name of ranitidine), the medicine used to treat conditions such as heartburn and stomach ulcers. Not all types are affected. The MHRA is advising that patients should not stop taking their medication, and do not need to see their doctor until their next routine appointment but should seek their doctor's advice if they have any concerns. The recall is a precautionary measure due to possible contamination of the active substance in Zantac, ranitidine, with an impurity called NDMA (N -nitrosodimethylamine) which has been identified as a risk factor in the development of certain cancers. Healthcare professionals have been told to stop supplying the products immediately, quarantine all remaining stock and return it to their supplier. An MHRA investigation into other ranitidine medicines which may also be affected is continuing and further updates will be provided as this investigation progresses. The MHRA has asked manufacturers to quarantine all ranitidine products which may contain the active pharmaceutical ingredient that is potentially affected by this issue.



N-Nitrosodimethylamine (NDMA), also known as dimethylnitrosamine (DMN), is a semi-volatile organic chemical, produced as by-product of several industrial processes and present at very low levels in certain foodstuffs, especially those cooked, smoked, or cured. NDMA is water-soluble, yellow in colour, and has little or no taste and odour. It is also used to create cancer in rats for cancer research. It is toxic to the liver and other organs and is a probable human carcinogen.



The recall flyer for the USA versions

The advice is that whilst this action is precautionary, the MHRA takes patient safety very seriously. The advice to patients is to keep taking their current medicines but should speak to their doctor or pharmacist if they are concerned and should seek their doctor's advice before stopping any prescribed medicines. Alternative medicines are available to do the same job e.g. proton pump inhibitors. At present there is no evidence that medicines containing nitrosamines have caused any harm to patients, but the Agency is closely monitoring the situation, and working with other Regulatory Agencies around world.

Welfare Rights Matters

with thanks to Steve Donnison Benefits and Work Publishing.

Claimants "Need Putting Down" Candidate Still Standing

Every day seems to bring news of another prospective MP who has been forced to stand down because of some appalling comments unearthed in their social media history. And yet, it seems, that saying that benefits claimants "need putting down" and laughing approvingly at the idea of attacking homeless people with a bat is too minor to require a Tory candidate to be replaced. Francesca O'Brien, who is standing in the Tory target seat of Gower made the comments five years ago on her Facebook page, after watching 'Benefits Street'. She has now retracted the remarks, saying ". . . my use of language was unacceptable, and I would like to apologise for any upset I have caused". Most people would probably consider that this went far beyond simply a poor choice of words. It is the hate-inciting and violent attitude that stood behind those words that would make most people consider O'Brien utterly unfit for public office. Sadly, the secretary of state for work and pensions, Therese Coffey, doesn't agree. She is happy to still endorse O'Brien as a parliamentary candidate, saying that it should be up to the people of the Gower to decide if they want her to be their MP.
We'll watch the result on the day with great interest.

Tribunals Service Overwhelmed by PIP Appeals

A report by the Tribunals Service admits that they can't keep pace with the number of PIP appeals.
The 'Senior President of Tribunals' Annual Report' admits that "the rapid rise in appeal numbers has outstripped our ability to recruit and train sufficient numbers of panel members to keep pace". Appeal numbers plummeted in 2013, from a high of over half a million, after the DWP introduced its cynical mandatory reconsideration hurdle. However, numbers are on the rise again, more than doubling from 112,000 in 2014 to 238,000 in 2018. To try to cope, the Tribunals Service appointed 130 new judges, 225 medically qualified members and 125 disability qualified members last year. They are also trying other methods to reduce the backlog, including cramming more PIP appeals into each session and trying to resolve more cases before they reach a hearing. But the one thing that would really cut their workload - the DWP getting more decisions right - is unlikely to happen any time soon.

Benefits Freeze to end next year

The five year long benefits freeze will finally end in April 2020, the government has announced.
However, the rise in benefits rates will be just 1.7% next year. According to a Resolution Foundation report, the freeze has left claimants 6% worse off than they would have been. The Foundation says that the real value of basic out-of-work support in 2020 will be lower than it was in 1992, adding that:

"Relative to earnings, unemployment support has fallen to a record low of 14 per cent, down from 27 per cent at the emergence of the Beveridge system"

So, over 70 years on, support is half of what it was when the country was just emerging from a devastating war.

DWP Guilty of Publishing False Claims

It's absolutely no surprise to learn that the DWP have been misleading tabloid readers about universal credit on a grand scale, at the taxpayers' expense. But what is surprising is that the Advertising Standards Authority (ASA) actually upheld complaints about the deliberately deceptive DWP adverts disguised as news. Regular readers will know that the DWP paid for an extensive 'myth busting' campaign in the Metro newspaper and online earlier this year. The project provoked a backlash from claimants, who organised the removal and destruction of many thousands of copies of the Metro from train and tube stations. Now the ASA has ruled that the advertising campaign must not be run again.

They decided that:

- the DWP claims that people on Universal credit (UC) move more quickly into work could not be proved;
- the DWP did not make it clear that UC advances are loans that have to be repaid;
- the DWP assertion that claimants could simply arrange for UC to be paid to their landlord was not true;
- the DWP obscured the fact that the online adverts were written by them and were not independent news.

The DWP, rather than apologising, simply says it is 'disappointed' with the decision.

New NICE guidance on Cannabis-based medicinal products.

Many years ago cannabis was deemed to be an obsolete drug, of no value to modern medicine. The most well know use of cannabis in the UK is as an illegal social or recreational drug. This total illegality is of course and is major problem involving addiction and driving crime. However, several cases Cannabis based products have recently featured heavily in the news with some parents importing from abroad medicines in desperation to treat their child health problems when all else has failed. The good news is that two cannabis-based medicines, Sativex and Epidyolex, for epilepsy and multiple sclerosis, have been approved for use by the NHS in England. This guideline covers prescribing of cannabis-based medicinal products for people with intractable nausea and vomiting, chronic pain, spasticity and severe treatment-resistant epilepsy. NICE is currently looking at guidance on cannabidiol with clobazam for treating seizures associated with Lennox-Gastaut syndrome and Dravet syndrome.

A summary of the NICE guidelines

The products covered are cannabis-based products for medicinal use as set out by the UK government in the 2018 Regulations. The licensed products delta-9-tetrahydrocannibinol combined with cannabidiol (Sativex) and nabilone plant-derived cannabinoids such as pure cannabidiol (CBD). synthetic compounds which are identical in structure to naturally occurring cannabinoids such as delta-9-tetrahydrocannabinol (THC), for example, dronabinol.

Intractable nausea and vomiting: This is when all else fails, for example with chemotherapy-induced nausea and vomiting. Consider nabilone can be considered as an add-on treatment for adults.
Chronic pain: NICE advises against offering nabilone, Dronabinol THC (delta-9-tetrahydrocannabinol) a combination of cannabidiol (CBD) with THC. It recommends that CBD should be used to manage chronic pain in adults unless as part of a clinical trial.
Spasticity: (a combination of disabling paralysis, increased tendon reflex activity, and hypertonia in skeletal muscle). The recommendation is to offer a 4-week trial of THC:CBD spray to treat moderate to severe spasticity in adults with multiple sclerosis, if other pharmacological treatments for spasticity are not effective. After the 4-week trial, continue THC:CBD spray if the person has had at least a 20% reduction in spasticity-related symptoms on a 0 to 10 patient-reported numeric rating scale. The treatment with THC:CBD spray should be initiated and supervised by a physician with specialist expertise in treating spasticity due to multiple sclerosis.
Severe treatment-resistant epilepsy: NICE has made research recommendations on the use of cannabis-based medicinal products for severe treatment-resistant epilepsy and is developing technology appraisal guidance on cannabidiol with clobazam for treating seizures associated with Lennox-Gastaut syndrome and Dravet syndrome.

When prescribing cannabis-based medicinal products, doctors should advise people to stop any non-prescribed cannabis, including over-the-counter, online and illicit products.

Hemp oil

Hemp oil is an oil extracted from the hemp plant. All plants in the Cannabis genus can produce the oil, but usually only industrial hemp is used to make hemp oil. Industrial hemp is a hemp variety which has been cultivated specifically for industrial production, and it has a minimum of the psychoactive substances associated with the genus, most notably THC. Hemp oil is typically almost free of THC, and it has no psychoactive properties.

Hemp seed oil is reputed "Nature's most perfectly balanced oil", due to the fact that it contains the perfectly balanced 3:1 ratio of Omega 6 (linoleic/LA) to Omega 3 (alpha-linolenic/LNA) essential fatty acids, determined to be the optimum requirement for long-term healthy human nutrition. In addition, it also contains smaller amounts of 3 other polyunsaturated fatty acids in gamma-linolenic acid (GLA), oleic acid and stearidonic acid. The EFA combination is unique among edible oil seed.

For further information please see
www.drmyhill.co.uk

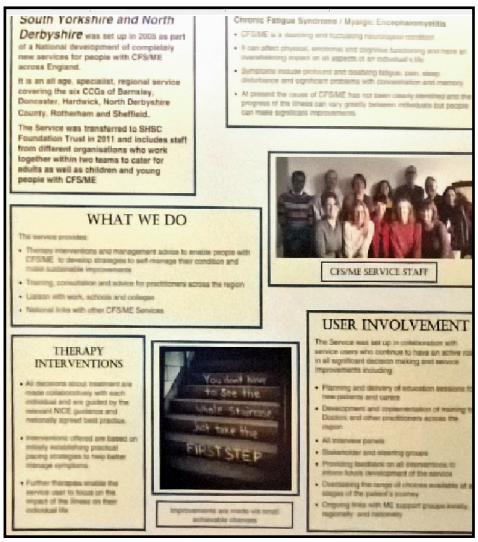
Sheffield CFS/ME Service Event- "Shaping the Way Together"

Ever since the Sheffield clinic was formed back in 2004, I have represented Leger ME at various meetings and events. The Clinic Lead, Ann Nichol stated the intention was to review the service to date, and then discuss in small groups and receive feedback. As people with ME/CFS fall into two groups, the same programme was run for the morning and afternoon shifts. A lunch was provided, and specific trays has been prepared for those who have dietary problems.

The clinic was started in 2004 as a result of the Chief Medical Officers Report on ME/CFS and then followed the NICE Guidelines for chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management GC53. This document is the basis of 'reason d'etre' for the clinic. Much of the work of the clinic has been based on NICE GC53. However, generally it was felt in ME circles that quite a lot of the guidelines fell short of what was practiced outside of the NHS and in other countries. The Guidelines are due to be updated next year, 2020 and we wait for the publication .with interest.

The service includes two teams – one for adults and one for children and young people. The service is available to individuals who have a provisional diagnosis of CFS/ME and are registered with a GP within the region and who have been unable to self-manage their condition with the advice and management provided from primary care. The treatments offered provide a range of specialist, evidence-based, therapeutic interventions to individuals with a diagnosis of CFS/ME. The interventions provided are dependent on the severity of symptoms experienced by, and the preferred choice of, the individual. All treatments within the CFS/ME Service are based on graded activity management strategies within a cognitive behavioural framework, including practical and psychological interventions to facilitate behavioural change to enable individuals to maximise their potential and make sustainable improvements. The clinic's main local strategy is to adopt Adaptive Pacing, as a variation to Cognitive Behaviour Therapy and Graded Exercise which the guidelines recommend.

The stated aim of the clinic is to provide a seamless regional service. The service is a rehabilitation clinic, which is therapist lead, to help patients manage their condition. There is a doctor available should there be any matters which may need medical intervention. The service has developed a DVD and offer the option of SKYPE telephone appointments which is very helpful for those who have difficulty in travelling to Sheffield. The most useful service I have found is for the clinic to provide Leger ME members with a supporting letter for welfare rights matters, which has proved invaluable for members dealing the Department of Work and Pensions.



An example of the many displays by the clinic at the conference.

One of the main issues raised is the waiting times. This was brought up at the discussion group I attended. What was quite clear is that the clinic is aware of this, it was felt that information should be provided earlier; maybe by email or post prior to the first face to face appointment. One concerning aspects is that all the appointment letters, and other documents are print on standard NHS manila paper. Several delegates felt that this cause difficulties in reading the documents. I raised the issue about coloured filters (Myers Irlen) as reading aids. Someone asked about using '*Stickmen'* type documentation. I raised the issue about the '*This is ME'* passport document, which was featured in *Pathways 60,* and left printouts. Other issues that I raised were about dual delivery and a satellite clinic somewhere in Doncaster. This was mooted many years ago but never materialised possibly due to budget limitations.

Finally, Ann announced that she would be spending less time in the clinic, but would be around. We wish her well for the future.

Recipe Corner

with thanks to Jack Monroe

Cannellini, leek and Sausage pasta.

Serves 4.

Cooking Method

1) First peel and dice your onion, if using a fresh one, and toss into a large non stick pan.

2) Peel and finely chop the garlic, and add that too.

3) Measure in the oil and cook on a low heat for a couple of minutes to start to soften the onion and garlic.

4) Pour over the stock and add a scant pinch of salt, and bring to the boil.

5) Drain and thoroughly rinse your cannellini beans, and add to the pan, along with the mustard and herbs.

6) Reduce to a simmer, for around 30 minutes, until the beans are soft and creamy.

7) Meanwhile, in a separate pan, heat a little oil and fry the sausages for 10 minutes, turning a couple of times to cook thoroughly throughout.

Ingredients

160g onion, fresh or frozen
4 fat cloves of garlic,
1 tablespoonful oil
a pinch of salt
500ml chicken or vegetable stock,
400g cannellini beans
1/2 tsp English mustard
1 tsp mixed dried herbs
6 sausages, defrosted
300g dried pasta,
160g green cabbage or spring greens
160g leeks

8) Remove from the heat and slice thinly, around half a centimetre if you can manage it, then add to the pan of beans for the remainder of the cooking time.

9) After thirty minutes have passed, measure the pasta into the pan and add 300ml more water.

10) Stir well and bring to the boil, then reduce to a simmer and cook for 10 minutes more.

11) Finely slice the leeks and cabbage and throw them into the pot for a few minutes to soften, then serve with plenty of black pepper to finish.

Variations for dietary preferences

Vegan readers –

You can make this with veggie or vegan sausages too

Gluten-free readers

Simply replace the pasta with your favourite gluten free pasta, but don't forget to check your sausages and stock cube are gluten free.

Depression and ME/CFS *(Thanks to Patient UK)*

Very often I find doctors confuse ME/CFS and depression as they share many common characteristics. Depression refers to both negative effects of low mood and/or absence of positive affect (e.g. loss of interest and pleasure in most activities and is usually accompanied by a variety of emotional, cognitive, physical and behavioural symptoms. It is the most common psychiatric disorder and carries a high burden in terms of treatment costs, effect on families and carers and loss of workplace productivity. Chronic physical illness increases the risk of depression. NICE Issued specific guidance regarding depression in adults with a chronic physical health problem like ME/CFS

Risk factors for Depression

- Female gender The gender difference is likely to be due to a complex interaction between biological, psychological and sociocultural vulnerabilities. (Men, however, have a higher risk of suicide.)
- Past history of depression.
- Significant physical illnesses, particularly those causing disability or chronic pain.
- Other mental health problems, such as schizophrenia or dementia.
- Psychosocial problems - e.g., divorce, unemployment, poverty.

According to the NICE guidelines (2020),to diagnose depression, this requires at least one of the core symptoms:

- Persistent sadness or low mood nearly every day.
- Loss of interest or pleasure in most activities.

Plus at least three or four of the following symptoms to a minimum total of 5 depressive symptoms:

- Fatigue or loss of energy.
- Worthlessness, excessive or inappropriate guilt.
- Recurrent thoughts of death, suicidal thoughts, or actual suicide attempts.
- Diminished ability to think/concentrate or increased indecision.
- Psychomotor agitation or retardation.
- Insomnia/hypersomnia.
- Changes in appetite and/or weight loss.

Symptoms should have been present persistently for at least two weeks and must have caused significant distress and impairment. They should not be due to a physical or organic factor (e.g. ME/CFS) or illness although illness and depression commonly co-exist).

Severity is based on the extent of symptoms and their functional impact:

- Sub-threshold depressive symptoms - less than five symptoms.
- Mild depression - few, if any, symptoms in excess of the 5 required to make the diagnosis, with symptoms resulting only in minor functional impairment.
- Moderate depression - symptoms or functional impairment are between 'mild' and 'severe'.
- Severe depression - most symptoms present and the symptoms markedly interfere with normal function. It can occur with or without psychotic symptoms.

Normal sadness exists along a continuum from clinically significant depression: differentiation is based on the severity, persistence and the degree of functional impairment and disability associated with the low mood.

Screening Depression is common but is often undetected by the medical profession. However, a diagnosis of depression in by a doctor has a sensitivity of about 50% and specificity of 81%, with the risk of misidentification outweighing the risk of missed cases. In other words, GPs may be good at ruling out those without depression but may need to consider more cautiously cases where depression might be present.

Somatisation is the most important cause of missed diagnosis. Many depressed patients present with somatic symptoms, and most of those where the diagnosis is missed, making it critical always to consider emotional health in a differential. Many patients seen have a pre-existing physical illness which can also divert attention away from their mental state. In the elderly, depression can present as pseudodementia, with abnormalities of memory and behaviour that are typical of true dementia. Clarification can be asked by a two-question approach:-

During the past month, have you:

Felt low, depressed or hopeless? And/OR Had little interest or pleasure in doing things?

Where there is a positive answer to either question, further evaluation should be triggered

Self-report symptom scales are widely used and include The Patient Health Questionnaire (PHQ-9) which is used in the ME/CFS clinics. Whilst these can be helpful in staging depression, do not rely on a symptom count alone to make a diagnosis of depression.

Doctors are told that someone considered likely to have depression should then be fully assessed: -

- Full history and examination, including mental state examination, enquiring directly about suicidal ideas, delusions and hallucinations. Consideration to organic causes of depression such as hypothyroidism or drug side-effects is needed. Establish the duration of the episode.
- Review of related functional, interpersonal and social difficulties. Involve family members or carers, with the patient's consent, to obtain third-party history if appropriate. Note whether there is evidence of self-neglect, psychosis or severe agitation. Consider cultural factors.
- Past psychiatric history, including previous episodes of depression or mood elevation, the response to previous treatment and parallel mental health conditions.
- Patient safety and risk to others - suicidal intent should be assessed regularly. The doctor should directly ask about suicidal thoughts and identify risk factors for suicide.
- Depression should be assessed as mild, moderate or severe, depending on the extent and impact of symptoms and level of functional impairment and/or disability. This will determine what level of treatment to initiate, following guidelines from NICE

.

Diagnosis

A Differential diagnosis should be considered that distinguishes depression from other problems from other problems that can cause similar symptoms. For example, ME/CFS, Bipolar disorder, Schizophrenia (depression may co-exist), Dementia (which may occasionally present as depression and vice versa), Seasonal affective disorder. In cases of bereavement: depressive symptoms begin within 2-3 weeks of a death (uncomplicated bereavement and major depression share many symptoms, but active suicidal thoughts, psychotic symptoms and profound guilt are rare with uncomplicated bereavement). There organic causes - e.g., hypothyroidism and drug adverse effects are an uncommon cause of depression. Some medicines that may cause depressed mood include: Centrally acting antihypertensives (e.g., methyldopa), lipid-soluble beta-blockers (e.g. propranolol often given to ME/CFS patients for fast heart rate). Benzodiazepines or other central nervous system depressants and Progesterone contraceptives, especially medroxyprogesterone injection.

Associated diseases should be ruled out.

E.g. Dysthymia (is a chronic depressive state of more than two years in duration), Eating disorders: anorexia nervosa and bulimia nervosa. Substance misuse is frequently associated with depression. Other psychiatric conditions may co-exist with depression (e.g., generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, personality disorders).

Some medical conditions have known associations with depression e.g. Parkinson's disease, Chronic diseases such as diabetes and cardiovascular disease. cerebrovascular disease, endocrine disorders such as hyperthyroidism, Cushing's syndrome, Addison's disease and hyperparathyroidism, Cancer, especially and auto immune conditions.

Investigations.

Investigations are used to exclude organic causes for depression; they are not mandatory and should be used according to clinical judgement. Blood tests may include blood glucose, U&Es, LFTs, TFTs, calcium levels, full blood count and inflammatory markers. Other tests may, when relevant, include magnesium levels, HIV or syphilis serology, or drug screening. Imaging (MRI or CT brain scanning) may be indicated where presentation or examination is atypical or where there are features suspicious of an intracranial lesion (e.g., unexplained headache or personality change). Seek specialist advice.

Management

Doctors and patients can use Decision Aids together to help choose the best course of action to take. General measures should include Managing comorbidity (particularly alcohol and substance abuse, eating disorders, dementia, psychotic symptoms), managing any safeguarding issues, assessing and mitigating suicide risk and Appropriate monitoring/follow-up. Advising on sleep hygiene where relevant. Traditionally, primary care management of depression has been concentrated on the use of antidepressants. There is now evidence supporting the efficacy of non-pharmacological alternatives, but these have frequently not been available. The Government has targeted additional money in order to develop new local services since 2008, known as 'Improving Access to Psychological Following is Physical activity programmes in facilitated group sessions. There is some evidence for efficacy of exercise in the management of depression. These have no place in ME/CFS.

Treatments.
Counselling or short-term psychodynamic psychotherapy for those who decline other interventions. Antidepressants are not recommended for the initial treatment of mild depression, because the risk to benefit ratio is poor. However, their use may be considered: If mild depression persists after other interventions or is associated with psychosocial and medical problems. In mild depression complicating the care of physical health problems, when a patient with a history of moderate or severe depression presents with mild depression. With subthreshold depressive symptoms present for at least two years or persisting after other interventions.

Treatment of moderate-to-severe depression
Offer antidepressant medication combined with high-intensity psychological treatment (CBT or interpersonal therapy (IPT) or behavioural couples therapy where relevant). (For an individual with a chronic health problem and moderate depression, this should be high-intensity psychological treatment alone in the first instance.

A doctor would make an urgent psychiatric referral if the patient has active suicidal ideas or plans, is putting themselves or others at immediate risk of harm, is psychotic, severely agitated or is self-neglecting. The use of the Mental Health Act may be necessary in some instances. Electroconvulsive therapy (ECT) is occasionally used by specialists to gain fast and short-term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life-threatening.

Antidepressants
What sort of antidepressant is best? Selective serotonin reuptake inhibitors (SSRIs) are used as first-line antidepressants in routine care because they are as effective as tricyclic antidepressants and less likely to be discontinued because of side-effects; also, because they are less toxic in overdose.
The evidence suggests antidepressants are effective in moderate-to-severe depression, but the evidence for efficacy in milder states is less clear. Hence NICE guidelines advise use in mild-to-moderate or subthreshold depression only where other interventions have not been effective.

Which SSRI?
NHS wise, a generic SSRI (e.g., citalopram, fluoxetine, paroxetine, or sertraline) when treating an individual with antidepressants for the first time, with the assumption that they have equivalent efficacy. However, newer evidence suggests that that escitalopram has the highest probability of remission and may be the most effective and cost-effective pharmacological treatment in a primary care setting, although there is a risk of overestimation of efficacy due to various types of bias

- Where a patient has concurrent physical health problems, sertraline may be preferred, as it has less risk of significant drug interactions.
- Where a patient has previously been treated for depression, doctors should be guided by past patterns of response/non-response to antidepressants.
- Treatments such as dosulepin (prothiaden), phenelzine, combined antidepressants and lithium augmentation of antidepressants should be initiated only by specialist mental healthcare professionals in the hospital environment.
- St John's wort should not be recommended because of uncertainty about appropriate doses, variation in the nature of preparations and potential serious interactions with other drugs.

Prior to initiating any medication, doctors should discuss the patient's fears of addiction or other concerns about medication. Over a quarter of patients newly prescribed an antidepressant by their GP never obtain their prescription or take more than a single dose. They should also the warned about expected side-effects and discontinuation reactions.

There is usually a delay in onset of effect (2-4 weeks), the time course of treatment should be at least six months from remission in symptoms to reduce the risk of relapse) and the need to take medication as prescribed. Remember the increased risk of bleeding with SSRIs, and consider co-prescribing a gastric protection agent, particularly in older people who are on aspirin or other NSAIDs.
Recent research findings have found a significant association between antidepressant use and incident diabetes, but the reason is unclear .

Monitoring and follow up
Patients who are not considered to be at increased risk of suicide, within two weeks of starting treatment and continue to review regularly as appropriate. Patients who are considered to be at increased risk of suicide or who are younger than 30 years old, within one week of starting treatment. Regularly review (every 2-4 weeks) in the first three months or until the risk is no longer significant. Where there is a high risk of suicide, prescribe a limited quantity of antidepressants and consider additional support such as more frequent contacts with primary care staff, or telephone contacts.

- Monitor for signs of akathisia (restlessness), suicidal ideas and increased anxiety and agitation, particularly in the early stages of treatment with an SSRI.
- Where there is partial or no response to medication at 3-4 weeks:
- Check adherence to and side-effects from the treatment.
- Consider increasing the dose of the antidepressant.
- Consider switching to an alternative antidepressant - initially ideally another SSRI, or alternatively another class of antidepressant - for example, mirtazapine, moclobemide, reboxetine, venlafaxine or a tricyclic. Washout times need checking. Always check guidance regarding switching and the need for 'wash out times' and careful dosage adjustment. Avoid tricyclic antidepressants or venlafaxine when there is a risk of overdose.

Research corner Intra-brainstem connectivity in ME/CFS

With thanks to ME Research UK

Earlier this year, Dr Elisha Josef and colleagues at Murdoch Children's Research Institute in Melbourne, Australia published results from their ME Research UK-funded study looking at brain functional connectivity, cognitive symptoms and fatigue in adolescents with ME/CFS. Also interested in this area of research is another Australian group, from a bit further up the coast in Queensland, which has recently published a paper investigating brainstem connectivity in adults with ME/CFS.

Functional connectivity describes the links that exist between different regions of the brain, and which allow information to be processed. Activity occurring in two regions of the brain at the same time suggests a connection between those regions – either in the form of a direct pathway, or a more indirect cause-and-effect.

The previous study in adolescents found that their functional connectivity – measured using magnetic resonance imaging (MRI) – was reduced following a period of mental exertion, and this was mirrored by a decrease in their performance on a number of tests of cognitive function. However, brain functional connectivity decreased by a similar amount in a healthy control group
.
In the more recent study – conducted by Dr Leighton Barnden and colleagues at Menzies Health Institute – the researchers assessed various regions of the brainstem in 45 people with ME/CFS and 27 healthy control subjects. Functional MRI was used to measure connectivity at rest, and while the participants were performing a series of tests of attention and concentration.

In these cases, deficits in intra-brainstem connectivity were found in the ME/CFS group compared with the healthy control group, but only while they were performing the cognitive tests. Specifically, connectivity was reduced between the medulla (responsible for autonomic function) and midbrain (motor function, and auditory and visual processing) within the brainstem, and between the brainstem and other parts of the brain.

The authors conclude that deficits in brainstem connectivity may help explain some of the autonomic changes in ME/CFS, as well as impairments in attention, memory, cognitive function and other symptoms.

Why do these results differ from those of Dr Josef's group? The most obvious answer is that the studies were looking at different patient groups. While the earlier study was in adolescents, the more recent study appears to have been in a group of adult subjects – their ages are not reported, but some of their characteristics and the fact they provided their own informed consent suggests they were adults.
In addition, the two studies were looking at different – although overlapping – regions of the brain, and there were also a number of other methodological differences between them.

Abnormalities in the brainstem of people with ME/CFS have been reported as far back as 1995, so it is good to see research continuing in this area, and we look forward to reading more from this group.

ME/CFS or Depression?- What are the differences?

Dr Sarah Myhill on her website says that doctors can be very naughty and intellectually lazy when it comes to diagnosing CFS. They are all too willing to label patients as depressed because this leads on to a straightforward and well recognised management protocol, namely, anti-depressants, exercise and, if you are lucky, counselling. If you suffer from CFS, anti-depressants in normal doses will make you worse, as will exercise. Counselling depends on the counsellor: If they do not believe CFS exists then you are well and truly stuffed.

There are clear distinctions between the two conditions, including the following:

1) Exercise: this makes CFS patients much worse but can be positively therapeutic in pure depression. This is the main difference!
2) Muscle tenderness and pain is common in CFS, and unusual in depression.
3) Response to alcohol and anti-depressants. These almost invariably make CFS patients worse, but depressed patients often get benefits.
4) Sleep disturbance: in CFS, the biological clock is moved on, so patients go to sleep late and wake up late in the morning. With depression, one expects to see early morning wakening.
5) Adrenal function. In CFS, this is usually depressed, whereas in depression, there may be associated anxiety, with raised levels of cortisol. CFS patients often have poor immunity, with recurrent infections. This is not generally a feature of depression.
6) If you can get the tests done, then there will be differences in neuro-psychometric testing, which demonstrate a different type of cognitive disturbance, memory loss and mental agility in both illnesses.

Furthermore, SPECT and PET scans demonstrate diminished metabolism in the brain stem, medial and frontal lobes of the cerebral cortex in CFS, whilst in depression, diminished metabolism is more widespread, and the frontal lobes are chiefly affected.

Recognising Coexisting Depression in ME/CFS

Dr. Charles Shepheard (Medical Director of the ME Association) explains in his book that the big danger for anyone suffering from a depressive illness is not being able to recognise that it is occurring. It may be all too obvious to family and friends, but not to the person whose mental health is steadily deteriorating. So, how can true clinical depression be separated from just feeling 'fed up' as a result of having ME/CFS?

There are a number of distinct features which are characteristic to all depressive illnesses. Three of them - namely fatigue, memory and/ or concentration problems and sleep disturbances - are all recognised features of ME/CFS. However, the exercise-induced fatigue and post exertional malaise experienced by people with ME/CFS aren't usually the sort of symptoms mentioned by people with mild to moderate depression. By comparison, their fatigue tends to be constant in nature and primarily stems from a lack of motivation or interest in doing any sort of physical activity. As far as problems with memory and concentration are concerned (cognitive function). There are various complicated types of psychological testing which indicate that there are some important differences between ME/CFS and depression. Equally, the type of sleep disturbances commonly found in ME/CFS (particularly the alpha wave intrusion) differ from those seen in depression.

Other important clinical features which help to differentiate ME/CFS from depression include:

A very sudden onset to ME/CFS, whereas depression tends to appear in a more gradual fashion. The presence of symptoms such as sore throats, enlarged glands, muscle twitching, joint pain, night sweats and disturbances in temperature control, which are common in ME/CFS but are not at all characteristic of depression. The absence of any of the core symptoms of depression (e.g. anhedonia (a total and complete loss of interest in all forms of activity) ,guilt, worthlessness, hopelessness and lack of motivation) in ME/CFS - unless, of course, the person concerned has also become clinically depressed. People with ME/CFS are frustrated by their inability to participate in work, hobbies or family pursuits which involve physical activity, but are still able to enjoy more passive pursuits. By

contrast, those with depression usually experience anhedonia.

Symptoms in ME/CFS are always exacerbated when people push themselves beyond their limits of physical or mental capability. Depressed people don't usually experience any ill-effects from exercise; on the contrary, they often feel better as a result. The highly characteristic phenomenon whereby physical or mental activity produces both physical and mental fatigue in ME/CFS is not a :finding that is remarked upon by depressed patients. A neurological component to ME/CFS consisting of clumsiness and unsteadiness is not characteristic of straightforward depression. In addition, there are also a number of important research findings which indicate that the biological abnormalities in ME/CFS are quite different from those found in depression.

These include: .

1) Lowered levels of cortisol in ME/CFS but raised levels in depression
2) Enhanced prolactin production following the administration of buspirone is found in ME/CFS but not in depression .
3) Different types of neurotransmitter abnormalities in ME/CFS compared to depression .
4) Significant hypoperfusion to the brain stem in ME/CFS but not in depression .
5) Different types of immunological abnormalities in ME/CFS compared to depression
6) The failure of ME/CFS patients - with or without depression - to respond to an SSRI antidepressant .

Even so, there are some important mood changes which would strongly suggest that someone with ME/CFS was becoming depressed. A combination of *three or more* of the following, occurring as 'new' symptoms, for more than two weeks, would indicate the need for urgent professional help:

1) Recent loss of appetite and/or weight
2) Change in sleep pattern to early morning wakening.
3) Sudden loss of interest in sex.
4) Apathy and complete withdrawal from social contacts and friends.
5) Pessimism, hopelessness and a complete loss of self-confidence.
6) Feelings of guilt
7) Inability to enjoy or sustain interest in passive activities.
8) Suicidal ideas or plans - which ***must*** be taken seriously even as a minor symptom.

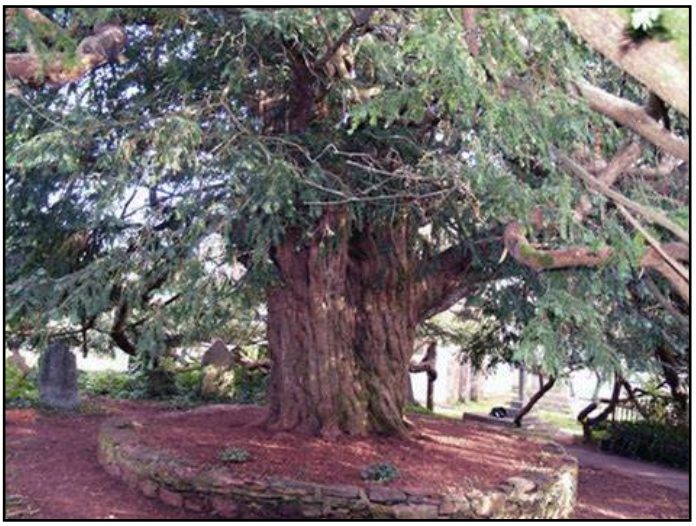
ME research UK to fund New study looking at nitric oxide (NO) production in ME/CFS

The immune system is a hot topic in ME research, with many studies published or currently ongoing. And we have recently awarded funding to Dr. Francisco Westermeier and colleagues at the Institute of Biomedical Science ,FH Joanneum University of Applied Sciences in Graz, Austria to explore immune abnormalities in ME/CFS. One consequence of an activated immune system is inflammation. This is part of the body's defence mechanism–increased blood flow to an injured area, and an influx of immune cells into the tissue to repair damage. But sometimes inflammation canpersistforlongerthanrequired,orbetriggeredunnecessarily,itself causing damage. Inflammation has been implicated in a number of cardiovascular conditions, specifically its impact on the function of the endothelium. This is a layer of cells lining every blood vessel involved in controlling their opening and closing, and hence the amount of blood flowing.

Some of the first research funded by us was conducted 20 years ago by a team at the University of Dundee looking at endothelial function in ME/CFS. One of the ways the endothelium controls blood flow is through the release of a chemical called nitric oxide (NO). But NO is a double-edged sword–while it is essential in normal endothelial function, too much can be damaging and lead to prolonged inflammation. Dr Westermeier is exploring this complicated relationship in more detail by looking at whether the cellular mechanisms that control NO production are altered in ME/CFS.

Using blood samples obtained from the UK ME/CFS Biobank, he will assess levels of NO and the proteins involved in its production. He will also investigate whether this is altered in endothelial cells exposed to ME/CFS blood samples. The researchers hope their findings will throw new light onto the role of these complex mechanisms in ME/CFS, and possibly identify new biomarkers. Dr Westermeier says that ME/CFS is "still poorly recognised in Austria, in part due to the lack of funding and research". He hopes this project will also help raise awareness of the condition in his country.

Evergreen Plants: The Yew Tree



Yew trees are associated with churchyards and gardens as they are extremely poisonous to livestock. A mature Yew can grow to 20m and is probably the most long-lived tree in northern Europe. The bark is reddish-brown with purple tones, and peeling. The leaves needle-like leaves which grow in two rows along a twig. Underneath, the needles each have a raised central vein.

Yew is dioecious, meaning that male and female flowers grow on separate trees. These are visible in March and April. Male flowers are insignificant white-yellow globe-like structures. Female flowers are bud-like and scaly, and green when young but becoming brown and acorn-like with age. Unlike many other conifers, the common yew does not actually bear its seeds in a cone. Instead, each seed is enclosed in a red, fleshy, berry-like structure known as an aril which is open at the tip.

Yew provides food and shelter for woodland animals. Yew hedges are incredibly dense, offering protection and nesting opportunities for many birds. The goldcrest and firecrest nest in broadleaf woodland with yew providing shelter. The fruit is eaten by birds, such as the blackbird, mistle thrush, song thrush and fieldfare; and small mammals, including squirrels and dormice which seem to be immune to Taxol, which is poisonous to mand and cattle. The leaves are eaten by caterpillars of the satin beauty moth.

Yew trees are associated with churchyards and there are at least 500 churchyards in England which contain yew trees older than the buildings themselves. It is not clear why, but it is thought that yew trees were planted on the graves of plague victims to protect and purify the dead, and also in churchyards to stop 'commoners' from grazing their cattle on church ground as yew is extremely poisonous to livestock.

Yew timber is incredibly strong and durable. Traditionally, the wood was used in turnery and to make long bows and tool handles. One of the World's oldest surviving wooden artefacts is a yew spear head estimated to be around 450,000 years old.

Taxol is and anti-cancer compounds are harvested from the foliage of Taxus baccata and used in modern medicine. Yew trees contain the highly poisonous taxane alkaloids that have been developed as anti-cancer drugs. Eating just a few leaves can make a small child severely ill and there have been some deaths linked to yew poisoning. All parts of the tree are poisonous.

Although Yew has a reputation for being indestructible, but it may be susceptible to root rot.

Craft Corner *by Carolyn*

Autumn is well and truly here, and I began to notice Pinecones of different shapes and sizes appearing in the house after my dog had been for his walk each day. This set me thinking that it might be nice to do something decorative with these free gifts, so what follows are just a few ideas for some Christmas decorations…

PINECONE MOUSE

To make a Pinecone mouse you will need:-

- One small Pinecone
- One Acorn cup
- Two large Pinecone scales
- Twine or a soft and bendable twig
- Brown paint, water based or Acrylic
- White paint, water based or Acrylic
- Glue (PVA works fine, but using a glue gun or craft glue will save time).
- A craft glue gun can be bought at Craft Stores or from Amazon at around £10

METHOD
Before you begin wash your pinecones carefully in water with vinegar and gently shake any loose bits out like seeds. Allow them to dry.

Step 1

Make your ears. Paint two large pinecone `scales` with brown around the outside and white in the middle. Water based paint is fine for this, but acrylic gives a more polished result. Once dry, trim the pointed ends if needed and glue into place on the top of your pinecone, quite close together.
Tip: You may want to balance all off your mouse parts in place first before attaching with glue to see what it will look like.

Step 2
Make your face. Using a small paintbrush, paint a small nose at the tip of the acorn hat. Paint two small eyes and a smile if you like too. Glue into place just in front of the ears.

Step 3
Curl a tail. Cut your twine or twig to tail-length. Wind it around your finger to bend into place and glue the end to the back of the pinecone.

Step 4
If you're using PVA glue, leave it to dry for a few hours or overnight and then you're finished!

Snow topped pinecones

A favourite, these look lovely grouped together in a basket or bowl, or just scattered on windowsills and around a fireplace.

Just take a big, open pinecone and apply white paint to the edges to look like snow. Once dried, you could add a little sparkle by dotting some of the scales with glue and adding silver glitter.

If you like you could also add small coloured lights into the basket or bowl.

North of Doncaster. *A Personal column by Trevor Wainwright*

Yorkshire spake (speak) translations.

Reyt	Right
Thee, tha, thy	you
Tha'll	you'll
Aye	Yes
neet	night
gerron	get on
gi	give
bi	by
In't	Isn't
nowt	nothing
weren't	wasn't
Alreyt	Alright
Tha's	You're
Tha'd	you'd
summat	something
Terneet	tonight
wi	with
leet	light
thissen	yourself
teld	told
owt	anything

A Castleford Nativity:

And it came to pass that a Governmental decree went out that all males should return to the town of their birth with their families to register for a forthcoming census. Bill, who before moving down South had been a Carpenter until the mine closed down, at a Coal Mine in a northern town called Castleford, had to return to there with his wife Lizzie who was pregnant and near her time. He had set up a small but successful Carpentry business in the South East despite it being during a time of austerity where he gained a reputation for fairness and as such, his business had not floundered as others had. This had been apparent to Lizzie who he had met when buying some timber she had asked his advice and they seemed to hit it off straight away, they courted and got engaged and such was his love for her that he respected her wish to remain a virgin till they married. A rare virtue these days she had thought in a world where identity was being lost, where they were in danger of becoming a sterile nation, individuality was being frowned upon lest it offend according to certain groups. Nevertheless, she looked forward to the day when she and Bill would have a family if their own. So, when she received the news from an Angel saying she was pregnant, she was deeply troubled, saying she was a virgin. The Angel told her the child she had conceived was Gods, she had found favour with Him and all would be well and when the child was born, she was to call him Brian. She felt a deep joy at this, even so it was with some trepidation that she went to tell Bill.

Bill, as expected was less than pleased when Lizzie told him the news! He was shocked but not the type to get angry and being a good man or what they call in Yorkshire "A reyt lad" did not want to disgrace Lizzie publicly. So, he decided to break the engagement quietly, but would need time to think about how. As he left Lizzie watched him go with heavy heart, his shoulders were slumped in despair, how she loved him, how sorry for him she felt, such a good man. As he disappeared down the street, she went to the sofa, sat down and began to weep gently. Would it all be worth it she thought, losing the man she really loved, and then she cried, bitterly.

Bill went away with his heart heavy and was unable to settle. He thought about the home he had hope to share with Lizzie after they had married, the work he had done to get it just right; they had worked together on what was a testament to his craftsmanship and pride in his work. His mind was in a whirl trying to make sense of it all and after a somewhat tasteless supper he went to bed, looked at the photo of Lizzie by the side of his bed and feeling the tears roll down his face he switched the light off, turned away and drifted off to sleep, he began to dream.

An angel of the Lord appeared to him, resting his hand on his shoulder and gently saying "Bill, do not be afraid to take Lizzie as your wife", it is not of her doing but God's. She would never betray you with any other, he explained things further adding that God had not gone into this lightly and preferring a child to have two parents, could think of no finer man to be a role model, and parent. Bill woke, the dream had been so real, almost as if he had felt the angel's hand on his shoulder, maybe Lizzie was right after all. After breakfast he called to see her, "Hello Bill" she said smiling, her eyes though red with crying shone when she saw him, his heart went out to her, he was glad to see she was still wearing his engagement ring, "come in" she added. They sat on the sofa and he told her about his dream, he said if she was still willing to marry him he would raise Brian as his own, she agreed, adding she would like nothing more. They hugged, tears flowed again, this time tears of joy as they set a date.

The marriage went well and they'd both been happy, enjoying planning for the new arrival. They even pretended to argue about names and what colour to decorate his room. Now it was time for the census and going back to Castleford would mean an early start, it would be a long drive and no time for doubt, there would be others doing likewise. It was still dark as they left their home, it would be Lizzie's first time there and in Yorkshire too. She had heard so much about it from Bill and was looking

forward to it. Others did have the same idea and what would normally have taken 30 minutes to get to the M25 took just over an hour. As expected the M25 around London was really slow, after what seemed an age they were finally on the M11, the open landscape was a bit more pleasant with better views but the sky was clouding up to the East as if threatening snow, as they drove North through Essex and Cambridgeshire and here the snow began to fall. They picked up the A14 West of Cambridge, which would lead them to the A1 and onward to the North. They had made rest stops but found the service stations busy so were glad they had decided to take sandwiches, nevertheless using the toilets had meant queuing. The A14 would have been a pleasant drive but for the snow slowing them down even more. As they got further North along the A1M, leaving Nottinghamshire for South Yorkshire, Bill thought of the coal mines and spoil heaps that once dotted the landscape, all gone now. Thankfully the snow was easing, and the constant traffic had stopped it drifting too much.

It was still snowing when they arrived to find Castleford busy. The hotels on the outskirts in the new developments were full, they would try in the town. Sadly, due to the austerity many of these had closed, some had been demolished whilst others had changed purpose, become convenience stores, a fish and chip shop, a vets and more, there were no rooms anywhere. At the last one in Smawthorne, the area in Castleford where Bill had lived and had been brought up, the landlord had apologetically told him he'd no rooms spare. They were just about to leave, they had brought blankets in case there were no rooms, they would sleep in their car if necessary, when a customer walked up asking "Bill it is thee in't it" the recognition was instant "aye John it is, I'm back for the census and looking for somewhere to stay" Bill said introducing his wife Lizzie. John, who had worked with Bill at the local mine said, "aye there's no room anywhere, even my house is full, but hang on a minute". Turning to the landlord he told him about Bill, how he was a local lad what he had done for the community before moving away for work, the census bringing him back with his wife Lizzie and her being pregnant, asking "surely there's summat tha can do, they can't sleep in their car on a neet like this". The landlord pondered for a bit and said "Aye if it would help, I have a storeroom and we could fix 'em up with a bed in there, and a small heater, not exactly 4 star but if it helps.

John took this back to Bill, who agreed, hopefully, something better would turn up later, "come on then" said the landlord" let's get to it, an' thy can give me a hand John" he said introducing himself as Clarry. "Bless you for this Clarry" said Lizzie, Clarry quietly replied "It's alreyt lass I wish I could do more". Soon the room was made ready, John had nipped out to the local chippy, coming back with some fish suppers, Clarry's wife had made them hot drinks and said "anything else you need just ask" Clarry was about to go back to his customers, "Why not join us one you've settled" he said, Bill looked at Lizzie who nodded, "yes we will thanks" he replied. "Thanks, Clarry" said John "it's reyt" Clarry replied "come on I'll stand thee a pint for helping". "Only one" "Tha's lucky to get that, cheeky sod".

Bill and Lizzie smiled at this discourse, after they had eaten, they began to settle feeling full of gratitude, it had been a long day. "You were right about Yorkshire people, they're lovely" Lizzie said. In the bar John was enjoying his free pint, thinking how nice it was to see Bill again, maybe they'd take in a match down the Lane, around him the conversation although quiet was about the two travelers. Back in the storeroom Bill and Lizzie were relaxing, when Lizzie said, "I think he's on his way". The tone in her voice confirmed it. Bill went to telephone for an ambulance but like the hotels, the ambulance service was busy, the snow had brought many road crashes, the austerity cuts had bitten deep into the public services, they could not give an arrival time.

"John nip an' bring Sheila from number 27 she's a nurse" said Clarry "she'll help". John was off like a shot returning with Sheila to find things were well in hand with hot water, towels and blankets, "We'll leave thee to gerron wi' its Sheila" said Clarry saying to John "I suppose tha'll want another pint?" "aye course" replied John smiling, "it wain't bankrupt thee." The atmosphere was somewhat subdued but pleasant; people were speaking quietly, the main topic again being Bill and Lizzie, how far they had come, and not so kind comments about the Government calling the census. There was a mood of expectation, then a faint cry was heard, "Sounds like she's had it" said one regular, "aye I wonder what it is" said another. Outside there was a sudden noise of celebration and flashes of light "someone's making merry" someone said, but inside people were more interested in the new arrival.

A short while later Sheila came out of the room smiling, the customers looked inquisitively at her, "what is it, what's she had then?" someone asked. "it's a boy" she said smiling "an' there's summat special

about him". "Are they all reyt? asked Clarry, "doing fine" Shelia replied, "it was as if things were meant to be, no complications". The atmosphere lifted "when do we get to see him?" asked John, "soon" replied Sheila "gi' em chance to settle". "Well it's drinks all round" said Clarry and looking directly at John added an' don't thee say owt". "As if I would" quipped John in return.

Sheila made a final check on the child and Lizzie, "Thanks Sheila, ever so much" said Bill, "you're welcome" She replied "I've got a feeling something special has happened tonight, as if it was meant to be. Bill thought "if only she knew" and said a silent prayer of blessing for her. A few at a time the locals went in briefly smiling at the bern and coming out "What's tha goin' to call him then" Bill let Lizzie speak, "Brian like we were told". At first it seemed a strange name, but the more they looked into the child`s face his eyes looking back at them, it was is if they saw something and understood, one customer even saying "one time bein' born here meant he'd be alreyt to play cricket for Yorkshire". Lizzie was puzzled till Bill smiling explained that at one time unless you were born in Yorkshire you couldn't play for the county cricket team, Lizzie found this amusing, asking why they had changed it, John looked up from looking at the baby Brian and winking at Bill quickly quipped, "To stop t'Southern teams beating 'em". The three of them laughed.

Later a group of workmen came in asking to see the new born child, Clarry asked how they knew, they replied, "that noise were the angels singin' tellin' us about new born lad, an' what he's gonna do, can we see him", "Aye" said Clarry "tha' knows I could have made a fortune here sellin' tickets". The workmen from a local building site had decided to work late to complete the job so it was not waiting for them after holidays, went into the room. "In't he grand" said the first, "aye fair bonny" added the second, the third looked quietly and asked, "What can we give him?" They felt in their pockets, the first found a small keyring torch, flicked it on, saying if it's as angels said he's goin' to be leet o' t'world he may as well have this, the second producing a ball said "let this ball represent his world he goin' to be the leet of", the third who, like Bill was a carpenter, produced a pencil from his overalls pocket saying "an' this'll represent those who will tell his story and spread his word. Wishing Bill and Lizzie well, they left quietly but smiling, went to the bar and ordered three pints, "these are on' t'house" Clarry said, "it's a good job it weren't twins" quipped John "tha`d have needed a bank loan, triplets and tha'd have been bankrupt". Clarry just smiled, he knew John meant no harm, and he'd had been a great help, he was just that type of man.

Following a few more drinks the builders decided to call for a takeaway and left saying they would not forget tonight in a hurry. Shortly after they'd gone Clarry called time, most of his customers were soon on their way home when a motor home pulled up outside, three men walked in each carrying a small parcel "It's gone time lads sorry" said Clarry looking up from a table he was wiping. "We don't want a drink" they replied politely. Seeing the parcels Clarry asked "have t'angels teld thee as well" "no it's summat we've been waitin' for an' we've followed a star from the East coast" they replied. We called at York first to t'home o' Province ruler but nowt was happenin' there, then t'star led us here". "By" said Clarry "it gets better bi t'minute, follow me" he led the three men to a small room, knocked on the door. "Some more visitors Bill" he said. "Ok thanks" said Bill opening the storeroom door, he invited them in and shook hands with them, they spoke briefly about a prophecy they had read about a star leading them to a newborn King and their journey there. Lizzie invited them to see the baby Brian and they looked on with pleasure at him, contentedly chewing on his knuckles. Now it's all coming true said the first one as he gave a gold coin with a crown on one side, a sign of hand a dove on the other, a sign of his Kingship and the peace he would bring. The second gave Frankincense for his Godhead, the third, Myrrh. It seemed a strange gift for a newborn, but there was something in the way it was given that it was more a gift relevant to his future, meaning there would be sadness before eternal joy. They left quietly but smiling after wishing Bill, Lizzie and Brian well, and went back to their motor home.

John who had been sat quietly at a corner table taking everything in was the last to leave, bidding goodbye to Bill, Lizzie and a last look at the baby Brian he heard Clarry say, "Come on lad get thissen home, they'll still be here tomorrow". "Thanks John an' thanks Clarry" Bill and Lizzie said, "tha's reyt" Clarry and John replied, Clarry walked with John to the door, neither noticing the bright star twinkling above the pub "It's been quite a neet" he said as they both shook hands. "Aye it has" said John. "Neet then Lad". "Neet" said John as he turned up his collar, and hands in pockets walked home along the snow-covered street thinking to himself. "Summat specials happened terneet, summat that's gonna change things for t'better, maybe not straight away, but one day, aye one day. While above the star began to move upwards into the heavens, its job done, it too was going home.