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Have a Great Summer



My Experience with a Tracheostomy

By David Cotcher, May 2017

I have had a tracheostomy for over 10 years and it has been successful in improving my health and quality of life. I previously wrote an article on My Polio Story in the May 2009 Polio PostBox, and another article entitled High Tech Breathing in November 2012, about the respiratory ventilator I use at night to help my breathing while sleeping. I would like to share some additional comments on my experiences with having a tracheostomy.

I had polio at about 18 months, and at age seven I started to have a curvature of my back that developed into a double curvature of my back and rib cage called kyphoscoliosis. This restricts my lung volume. Muscle weakness also affects my breathing, which is worsened when laying down, resulting in not breathing deeply enough when sleeping. I was prescribed supplementary oxygen usage starting in 1995 after I had pneumonia. This allowed me to get sufficient oxygen with less effort, but can compound the problem of my lungs not getting rid of the CO2 build up in my blood. For many years, I mainly used oxygen on exertion and at night, and was still able to work full time, travel, and be active.

In 2006 after a lung infection, my respiratory condition declined and I went back on full time oxygen. As I needed to use more supplementary oxygen, my condition continued to get worse later in 2006. I slept a lot and had trouble with memory and

struggled with functioning at work or at home. I did not realize at the time the problem was increasing CO2 level in my blood. Despite this I kept going to work, to church, and other activities. I think I was in denial of my worsening health condition.

Then in January 2007 I ended up in hospital emergency and was found to have low oxygen level and high CO2. I was in hospital about 10 days in January, and another 10 days in early February with worsening respiratory condition. I was using a BIPAP (Bi-level Positive Airway Pressure) machine with a mask while sleeping which helped stabilize my condition for a while, by allowing my lungs to better exhale the CO2. My condition worsened and I was back in hospital with respiratory failure from

IN THIS ISSUE

My Experience with a Tracheostomy	1
Message From the President	3
At the Meetings	4
Post-Polio Pharmacy Presentation	4
Children in Church	5
Medical Cannabis	6
Members We Have Lost	11
You Are Invited	12
Membership Application	12

high CO2 in my blood later in February. I was in critical condition with my oxygen level down to 31% and my CO2 level 3 to 4 times normal. High CO2 leads to being incoherent, then unconscious, and then to death. When I regained consciousness about two days later I found that I was intubated and on a respiratory ventilator in ICU. After discussing with the specialists, I had surgery to have a tracheostomy tube, and continued using a respiratory ventilator to help keep my CO2 level under control.

With the initial trach tube, I had in hospital, I had some emergency situations with my breathing restricted. Examination by doctors found that the tube was not flexible enough to follow the curvature of my trachea caused by my kyphoscoliosis. It was rubbing against the side of the trachea and causing a sore area called granuloma. This is one of the risks of a trach tube and can get worse and bleed if not treated. My trach tube was replaced with a Bivona Hyperflex trach tube made of silicon with wire reinforcement to keep the tube from kinking when it bends. It is 11 mm outside diameter and 8 mm inside diameter. Initially the length was adjusted until the granuloma healed up, and then a final length of 95 mm was selected.

I was there in Regina General Hospital recovering until going home in mid April 2007. I improved quite well and I was able to go back to work part time by June that year and continued working until retirement in 2011. I still have a trach tube and use the ventilator at night to improve my breathing while I sleep. Follow up tests show that my CO2 level is still under control.

I have had follow up appointments with the ear, nose and throat (ENT) specialist who examines around and below my trach tube with his bronchoscope. He looks for any granulation, which would be scar tissue or sore areas caused by the trach tube. Everything has healed up very well and the results of these examinations have been very good. I have not had any problems since using the Bivona Hyperflex trach tube.

At first I was having trach tube changes once a month, but now we have extended it to 6 weeks. I have had the same respiratory therapist for several years who does the procedure at the Wascana Rehabilitation Centre. The process to take one tube out and put the

other one in only takes a few minutes. It usually does not hurt but does cause some coughing afterward, and my voice may be hoarse for a while that day. I clean the tube that comes out, and have it ready for use next time. I just wash it in soapy water, rinse, and then put it into boiling water to sanitize it. I have now had trach tube changes 85 times so it has become routine. I reuse the same 2 trach tubes 8 to 10 times which lasts about 2 years of total usage. Then we start with new replacement tubes.



Trach Tube with Cuff Deflated and Inflated

The picture of a trach tube on the left shows the cuff deflated like I have it during the day, and on the right with the cuff inflated like I have at night. During the day air can go around the outside of the tube through my vocal cords, and through my mouth and nose.



Trach Tube with HME

With the cuff inflated at night the trachea is sealed off so the air from the ventilator goes directly to my lungs, and none escapes through my mouth and nose. Then I can only talk with a whisper.

The picture shows the connection to my trach tube with a Hydro-Trach heat and moisture exchanger (HME) and oxygen tubing. The HME filters the air and retains humidity. When using the HME, to speak I remove it and put my finger over the end of the trach tube, allowing air to go up past my vocal cords. I use a speaking valve when I go out, but at home it is more comfortable with the HME



Trach Tube with Speaking Valve

The picture shows a Passy-Muir speaking valve with oxygen connector like I use. I wear a scarf over it for protection when I go out. The speaking valve has a small diaphragm that opens to allow breathing in through the trach tube. When I exhale the diaphragm closes and I exhale through my mouth or nose. This way the air goes up past the vocal cords allowing me to speak.

At first, care with a trach tube was a big learning experience. Cleanliness is vital to preventing infections. I wash my hands frequently, and have a bottle of hand sanitizer beside the bed. I use a suction machine beside my bed to keep the trach tube cleared out as needed. A suction catheter, which is a long tube, suctions respiratory secretions out of the trach tube, that could build up and cause an obstruction if not kept clear. Suctioning can become frequent day and night if I have a cold, but normally it is only in the evening before connecting to the ventilator, and again in morning when disconnecting. These procedures took some learning and practice but now have become routine.

I thank God for the good health I have had for the last 10 years with a tracheostomy. Having a tracheostomy does have risks and challenges, but with the support I have had, I have managed very successfully. I appreciate the care I have had from the medical professionals, and the help and support of my wife Elaine and family. I have also had a lot of encouragement from the people of our church and our friends, including our friends at Polio Regina.

Message from the President



Hello to all of our faithful members of Polio Regina and their families. We are currently still in Park City, Utah enjoying the sunshine and beautiful mountain scenery! The snow melting from the

tops of the mountains, is rushing down behind the condo, babbling as fast as it can, downhill! We have yet to find out where it is rushing to, but we could watch and listen to it forever!!!

We have visited many returned missionaries and enjoyed their company in their own environment! Wilf's cousin, Bryce, lives in Providence, Utah, which is right beside Logan, Utah. You cannot tell when you are in one or the other. We could watch cows, sheep, goats and chickens grazing from the table where we ate or were just chatting.

Anyways, this is certainly a State to travel throughout, if anyone wants to see amazing mountains, rock formations or streams galore running along the side of the highways. The ski slopes, and there are many, are just about all melted now. We are about 5 miles from the Olympic site in 2002, so we can visit the bobsled and ski jumping site where there is a museum. We could do the Gondola for a small fee but I need not go any higher. My ears tell me that!! Lots of over-priced art for sale, a real touristy place but still maintains the antiquity of old times when it used to be just a booming mining town.

We are grateful we can still travel and see all of this but know it will soon be harder and harder to travel.

Looking forward to seeing all of you at the Spring Picnic at Nicky's.

Love from Carole and Wilf



At the Meetings

November 2016 - Open Forum: We had a presentation by Asha Hivarajan, who is a nurse at the complex in Weyburn where Doc Bornholdt is living. She has worked in India distributing the polio vaccine. She spoke about the history of polio in India and the work that went into making the country polio free.

Christmas party: We all enjoyed a turkey dinner with all the trimmings and were able to visit with fellow members after the meal.

March 2017 – This was our annual general meeting. Treasurer David Cotcher presented the annual financial statement for 2016 with comparative figures for 2015.

Election of executive officers for 2017.

The following are the Executive Officers of Polio Regina Inc. for 2017-2018:

President – Carole Tiefenbach

Vice-President – Wilf Tiefenbach

Secretary – Ivan Jorgensen

Treasurer – David Cotcher

Phone Co-ordinator – Carole Tiefenbach

Archivist/Librarian/Web Master – Peter Huang

Post Box Editor – Ivan Jorgensen

Director – Blenda Ramsay

Open forum: Diane Lemon introduced Myla Wollbaum, Director of Professional Practice from the Pharmacy Association of Saskatchewan, who was our guest speaker. She spoke about the different kinds of pain and the different methods of dealing with pain and the ways that pharmacists can help us. A summary of her presentation and other information is included in this issue.

April 2017 - Open Forum: The open forum was chaired by Diane Lemon who introduced our guest speaker Adine Enns, who is a dietitian from the Regina Community Clinic. She spoke about getting a balanced diet using all four food groups; prebiotics, probiotics and gave examples of easy sources of protein as well as other helpful advice.

Location and times of future meetings – we decided to continue to hold the meetings at Nicky’s Café but in the room on the west side of the Café where the chairs are easier to move. The fall meetings will be Thursday, September 28th and Thursday, October 26th, both at 3:30 p.m.

The following is the presentation by Myla Wollbaum BSP from the Pharmacy Association of Saskatchewan who was our guest speaker at our March Polio Regina meeting and is reprinted with her permission.

Post Polio Presentation

What pain treatments have you used?

What type of pain are you using them for?

Which were successful?

- OTC(Over The Counter)/herbal
- Prescription
- Non-drug

Pain Education– acute vs chronic

Acute pain usually comes on suddenly and is caused by something specific. It is sharp in quality. Acute pain usually does not last longer than six months. It goes away when there is no longer an underlying cause for the pain. Causes of acute pain include:

- Surgery
- Broken bones
- Dental work
- Burns or cuts
- Labor and childbirth

After acute pain goes away, a person can go on with life as usual.

Chronic pain is pain that is ongoing and usually lasts longer than six months. This type of pain can continue even after the injury or illness that caused it has healed or gone away. Pain signals remain active in the nervous system for weeks, months, or years. Some people suffer chronic pain even when there is no past injury or apparent body damage. Chronic pain is linked to conditions including:

- Headache
- Arthritis
- Cancer
- Neuropathic (Nerve) pain
- Back pain
- Fibromyalgia pain

People who have chronic pain can have physical effects that are stressful on the body. These include tense muscles, limited ability to move around, a lack of energy, and appetite changes. Emotional effects of chronic pain include depression, anger, anxiety, and fear of re-injury. Such a fear might limit a person's ability to return to their regular work or leisure activities.

Neuropathic pain is a complex, chronic pain state that usually is accompanied by tissue injury. With neuropathic pain, the nerve fibers themselves may be damaged, dysfunctional, or injured. These damaged nerve fibers send incorrect signals to other pain centers.

Different treatments for acute vs. chronic!!

OTC pharmacy

- Acetaminophen (Tylenol)
- Ibuprofen (Advil)
- Aleve- naproxen
- Voltaren
- Herbals
- Robaxin

Prescription Drugs

- NSAIDs – diclofenac, naproxen, celebrex
- Muscle Relaxants (flexeril)
- Narcotics
- Antidepressants (TCAs,- Amitriptyline, Cymbalta, SSRIs – celexa, paxil)
- Anticonvulsants/anti-seizure (gabapentin, lamotrigine, Lyrica)

Medical Cannabis

- Substantial evidence for chronic neuropathic pain in adults
- Moderate evidence for sleep, chronic pain and more
- >150 reported uses
- Some long term risks reported
- THC:CBD ratio

- Inhale and ingest (swallowing: liquid or baked into food)
- Process for obtaining

Non-Drug Treatments

- TENs machine, Dr. Ho
- *Cognitive Behavioral Therapy (CBT) – substantial evidence for all types of chronic pain
- Meditation
- Relaxation
- Yoga
- Hypnosis

PPS Treatment Review

- (Some) positive results:
 - IVI (muscle strength, but was inconsistent)
 - Lamotrigine
 - Muscle strengthening of thumb
 - TENs
- **Low or no results:**
 - Modafinil (propranolol) narcolepsy
 - Pyridostigmine (mestinon) myasthenia gravis
 - Amantadine parkinsons
 - Prednisone
 - Rehab specifically in warm (>25c) or cold climate (0c)

Myla Wollbaum BSP

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CHILDREN IN CHURCH

3-year-old Reese:

‘Our Father, Who does art in heaven,
Harold is His name.
Amen.’

A little boy was overheard praying:

‘Lord, if you can’t make me a better boy, don’t
worry about it.
I’m having a real good time like I am.’

One particular four-year-old prayed,

‘And forgive us our trash baskets
As we forgive those who put trash in our baskets.’

A Sunday school teacher asked her children as they
were on the way to church service,

‘And why is it necessary to be quiet in church?’
One bright little girl replied,
‘Because people are sleeping.’

MEDICAL CANNABIS

Updated April, 2017

Disclaimer: *This document is an interpretation of the Access to Cannabis for Medical Purposes Regulations (ACMPR) and the College of Physicians and Surgeons of Saskatchewan Bylaw 19.2. Please refer to latest legislation for up to date and complete information.*

As of September 2016, over 98,000 Canadians are registered with Health Canada to obtain medical cannabis. This number has more than tripled since September 2015 when just over 30,000 clients were registered. It is estimated that this number will grow to 500,000 or more, within the next 10 years.

LEGISLATION AND REGULATIONS

- Schedule II, Controlled Drugs and Substances Act, cannabis is considered a “controlled substance”.
- Canadian regulations have changed over time:
 - **2001 - 2014: Marijuana Medical Access Regulations (MMAR):**
 - Patient use was authorized by Health Canada,
 - could only be prescribed for specific indications (e.g. chronic illness such as MS),
 - patients were legally able to grow once authorized,
 - and product safety/quality was not enforced (e.g. varying levels of THC).
 - **2013 to 2016: Marijuana for Medical Purposes Regulations (MMPR):**
 - Patient use must be authorized by a physician (or nurse practitioner in some jurisdictions),
 - medical marijuana could be prescribed for any indication,
 - patients must obtain marijuana or product from a licensed producer,
 - production became highly regulated, lab tested quality assurance.
 - Since June 2015, licensed producers can sell cannabis oil and fresh cannabis buds and leaves in addition to dried cannabis. Patients may legally possess cannabis in forms other than just dried leaves (e.g., they can make their own edibles).
 - **August 2016 to now: Access to Cannabis for Medical Purposes Regulations (ACMPR)**
 - New regulations in response to Federal Court ruling in *Allard vs. Canada* which declared the MMPR infringed upon the Canadian Charter of Rights, citing lack of reasonable access to medical cannabis for patients.
 - Patients can now obtain cannabis for medical purposes one of three ways:
 - A) Register with a licensed producer and receive their order in the mail (same method as under MMPR)
 - B) Register with Health Canada to produce their own cannabis
 - C) Register with Health Canada to designate someone else to produce cannabis for them
 - licensed producers may provide the seeds, growing supplies, and interim supply of cannabis for patients who choose to produce their own supply or designate someone else to.
 - Review <http://laws-lois.justice.gc.ca/eng/regulations/SOR-2016-230/index.html> for most current legislation.
- “Compassion Clubs”, “dispensaries” or other unregulated store fronts selling marijuana are not licensed producers; they are unregulated establishments and clients may not be aware that purchases have not been legally attained.
- Minimum Prescribing Standards in Saskatchewan (College of Physicians and Surgeons of SK, Bylaw 19.2)
 - Prescribing physician must be primary practitioner treating the condition cannabis it being used for.
 - Patient must sign a written treatment agreement with the prescribing physician.
 - Physicians must keep a separate record to provide to the College of Physicians and Surgeons.
 - Physicians may not store or dispense medical marijuana.
 - See Bylaw 19.2 for complete information:
<https://www.cps.sk.ca/imis/Documents/Legislation/Legislation/Regulatory%20Bylaws%20-%20August%202015.pdf>

PROCESS FOR OBTAINING MEDICAL CANNABIS

- Clients may:
 - purchase a supply from licensed producer
 - produce their own supply
 - designate a person to produce supply

- Clients must first consult with their physician to obtain a *medical document*: an authorization to purchase, often referred to as a prescription.
 - All physicians in Saskatchewan may write a medical document for medical cannabis. A sample medical document is available here: <http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/med-eng.php>.
 - The medical document specifies the dosage and type of products the client may use.
 - The period of use stated in the medical document cannot exceed one year. Sample medical document: http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/info/med-eng.pdf
 - No list exists of physicians that are actively providing medical documents.
 - Nurse Practitioners may not prescribe medical cannabis in Saskatchewan.
- If purchasing, clients must register with a licensed producer of their choice. The most efficient method is for the physician to fax the medical document and completed registration application form from their office to the licensed producer.
 - The list of licensed producers and their contact information may be found here: <http://www.hc-sc.gc.ca/dhp-mps/marihuana/info/list-eng.php>
- If growing their own or having a designate grow their supply, clients must submit the original medical document and a registration application to Health Canada.
 - The Health Canada registration forms for growing are available at: <http://healthycanadians.gc.ca/alt/pdf/drugs-products-medicaments-produits/buying-using-achat-utilisation/cannabis-medical/access-acces/personal-production-personnelle/registration-form-formulaire-inscription-eng.pdf>
- Following registration with a licensed producer or Health Canada, the patient may order a cannabis product or the seeds and interim supply (if they choose to grow their own) from the licensed producer. The product will be shipped directly to the patient's home.
- Anecdotally, the time from submission of registration to time of delivery may be approximately 48 hours.

THERAPEUTICS

- The leaves and flowering tops of the cannabis plant contain at least 400 active non-cannabinoid compounds (e.g., terpenes, flavonoids) and more than 70 different cannabinoids.
 - Currently the two main therapeutic cannabinoids that have been identified are tetrahydrocannabinol (THC) and cannabidiol (CBD).
- The two most common species are Sativa (typically considered to be energizing) and Indica (considered to be more relaxing). Commercially available products may be hybrid combinations of species.

Human endocannabinoid system

- The endocannabinoid system has cannabinoid receptors throughout the body and is involved in a broad range of physiological processes. There are still other receptors not yet known.
 - *CB1 receptors*: predominantly expressed on the neurons in the brain and nervous system. Inhibits neurotransmitter release. Also found to a lesser extent in other areas, such as the adipose tissue, heart, lung, and bone.
 - *CB2 receptors*: predominantly expressed on the cells of the immune system.

Cannabis activity

- Tetrahydrocannabinol (THC):
 - Mixture of stimulant and depressant effects; this is the main cannabinoid that is psychoactive and create a "high".
 - elevated mood, relaxation, appetite, paranoia, depression, anxiety, hypertension, tachycardia
 - Partial agonist of CB1 and CB2 receptors.
 - Exists in the cannabis plant as mostly inactive THC-acid. Heating is required to decarboxylate the THC-acid into active THC.
- Cannabidiol (CBD):
 - Does not cause a psychoactive "high".
 - CBD does **not** bind significantly to CB1/CB2 receptors but affects activity of other enzymes and

- receptors.
- Potential anxiolytic, neuroprotective, anticonvulsant, analgesic, antiemetic and anti-inflammatory effects.
- Through an *entourage effect* may act synergistically with THC and may also lower the degree of psychoactivity caused by THC.

Pharmacokinetics:

- Highly lipophilic, wide distribution in tissues (large volume of distribution), long terminal half-life (4 days or longer), undergoes hepatic metabolism thus high clearance rates are associated with extensive first pass metabolism, excreted via biliary tract into feces along with urinary excretion of acid metabolites.
- *Smoking/vaporizing* cannabis has an onset within 3-10 minutes, higher blood levels, and a duration of action of 2-3 hours. Cannabis absorption and serum concentrations are influenced by the number, duration, and spacing of puffs, breath holding time, and inhalation volume.
- *Orally ingesting* cannabis has an onset of 60-90 minutes and typically lasts about 5-8 hours. Bioavailability and absorption are erratic, and dependent on gastric pH/administration in relation to foods.

Drug Interactions

- PK: THC induces CYP1A2; CBD inhibits CYP3A4 & 2D6.
- PD: potential for additive effect with CNS depressants and anticholinergics.

Dosing and Other Options

- Various surveys published in the peer-reviewed scientific and medical literature have suggested that the majority of people using smoked or orally ingested cannabis for therapeutic purposes reported using the equivalent of up to **three (3) grams of dried marijuana per day**, source: [Health Canada Information for Health Care Practitioners](#)
- 1 “joint” is usually 500-750 mg of dried cannabis. Medical cannabis costs approximately \$3- \$15/gram from a licensed producer depending on the ratios of THC:CBD.
- Given the erratic absorption and extensive first pass metabolism of orally ingested cannabis, doses need to be approximately 2.5x higher than smoked cannabis (oral dose of dried cannabis (mg) = 2.5x smoked dose (mg)). Note: this is not a direct conversion. If changing routes, suggest starting at low dose and titrating upwards to effect.
- Synthetic cannabinoids available in Canada include nabiximols (Sativex™) and nabilone (Cesamet™).
- **Dosing: Start Low, Go Slow** → No precise dose but inhaled is the most well studied route.
 - Average reported use is 1-3 grams per day, with Health Canada market data indicating an average of 2.6 grams per day.
 - The dose is highly individualized and relies on titration. First time users should consume their dose slowly by waiting at least 5 minutes between single puffs and waiting 2-3 hours between bites of oral products.
 - First time users may be at risk of overconsumption and undesirable effects.
 - Licensed producers have fixed ratio THC:CBD products for purchase.

USES:

- Conclusive or substantial evidence that cannabis or cannabinoids (includes both synthetic and plant-derived cannabinoids) are effective for:
 - Chronic pain in adults (cannabis)
 - Neuropathic pain: <34 mg THC/day associated with subjective improvement in refractory moderate intensity neuropathic pain in adults using concurrent analgesics.
 - Chemotherapy-induced nausea and vomiting (oral cannabinoids)
 - Patient-reported multiple sclerosis spasticity (oral cannabinoids)
 - Cannabis has only been studied in randomized control trials via the smoked/vaporized route, and only for chronic neuropathic pain.
- Moderate evidence that cannabinoids are effective for:
 - Improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (cannabinoids, primarily nabiximols)
- No large landmark trials.
- More than 150 reported uses, such as: anorexia/cachexia associated with HIV/AIDS or cancer, chronic pain syndromes (including cancer), anorexia nervosa, multiple sclerosis, spinal cord injury, bladder dysfunction associated with MS or spinal cord injury, amyotrophic lateral sclerosis, epilepsy, headache and migraine, arthritides (e.g., osteoarthritis, rheumatoid arthritis, spondylitis, gout, etc.) musculoskeletal disorders, fibromyalgia, dystonia, Huntington’s disease, Parkinson’s disease,

Tourette's syndrome, glaucoma, asthma, hypertension, anxiety and depression, sleep disorders, PTSD, Alzheimer's disease and dementia, inflammatory skin diseases (dermatitis, psoriasis, pruritis), GI system disorders (e.g., inflammatory bowel disease, hepatitis, pancreatitis, metabolic syndrome/obesity).

RISKS AND SIDE EFFECTS

- Short Term Effects (mostly linked to THC): dizziness, dry mouth, nausea, psychomotor deficits, increased risk of motor vehicle accidents, increased risk of falls in the elderly, associated with psychosis and higher THC doses associated with 5 fold risk of MI within 1 hour of smoking.
- Long Term use: Tolerance to some of cannabis' effects tends to develop after a few doses and also disappears rapidly following cessation. This includes effects on mood nausea, and the cardiovascular system but tolerance does not appear to develop for pain and spasticity. Tolerance is linked to the down regulation and desensitization of CB1 receptors.
 - Has effects on cardiovascular system (changes in blood pressure, heart rate, may increase risk of angina, exacerbate arrhythmias) and reproductive system.
 - Long-term users show deficits in prospective memory and executive function.
 - May be a trigger of psychotic events for individuals who are predisposed (e.g., schizophrenia, bipolar). Overall, effects on mental health unknown, use caution.
 - Risk of dependence and substance use disorder.
- Inhaled cannabis is not necessarily "safer than tobacco use": there are similar or higher amounts of carcinogens and polycyclic aromatic hydrocarbons. Cannabis users also tend to inhale more deeply and hold breath longer than tobacco smokers. Does not appear to cause COPD or increase risk of lung cancer but does cause symptoms of chronic bronchitis (cough, wheeze, phlegm) and may also decrease one's ability to fight infection (e.g., increased risk of pneumonia). Risk increases with higher doses and longer-term chronic use.
- Special populations:
 - **Adolescents**: Generally CONTRAINDICATED in less than 25 years of age because of structural brain development resulting in increased risk for schizophrenia and psychosis.
 - **Pregnancy**: No morphological abnormalities BUT potential loss of executive function at age 3 (inattentive, impulsivity, aggressive, difficulty problemsolving).

DOCUMENTATION

- At this time, "Dried marijuana is not an approved drug or medicine in Canada. The Government of Canada does not endorse the use of marijuana, but the courts have required reasonable access to a legal source of marijuana when authorized by a healthcare practitioner." (HealthCanada)
- Cannabis is not a regulated prescription medication or natural product; it does not have a DIN or NPN, and therefore cannot be documented in PIP at this time. Pharmacists are encouraged to document its use on the patient's file when possible.
- Patients are provided with a "carrying card" with each purchase. This includes, amongst other details, the period of time in which the medical cannabis for that order is to be used for. A new carrying card, with a new date, is provided with each new supply.
 - Medical Cannabis is legal in Canada and patients should always carry their carrying card and registration documents; patients crossing international borders may face serious consequences importing medical cannabis.

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Members We Have Lost

Muriel Lindsay-Ewing attended Polio Regina meetings for many years but for the last couple of years we had not heard from her.

Muriel LINDSAY-EWING



Muriel Lindsay-Ewing of Regina, died January 22, 2017 after months of struggle with ill health. Born November 21, 1930 in the Craven, SK area to James Lindsay-Ewing and Helen Munro Lindsay-Ewing, she grew up on the family farm in the Kennell District with her four

sisters, Daisy Dunsmore, Isabel Zerr, Jean Dench, Mae Krogsgaard.

Muriel devoted her life to family, friends and her church. She returned to Regina after living and working in Winnipeg, Montreal and Toronto, making fast friends with co-workers and her extended church family in each city. She had an entertaining sense of humour and easily shared her life story, always honouring those who had gone before her. She resisted personal birthday celebrations and photographs whenever she could. As a younger woman she enjoyed travel, but that part of her life was curtailed in later years due to ill health. Aunty cared deeply about those in need and habitually carried coins for people asking for help on downtown streets – always wanting to do more. She held high expectations for herself and others and her praise was genuine. Her games and play with babies and children were a special talent. Muriel's advice, love and unique perspectives on people and their circumstances will be remembered and greatly missed.

Muriel was predeceased by her parents, sisters and nephews Glen Dunsmore, Levi Krogsgaard and Jon

Dench. She is lovingly remembered by brother-in-law, Borden Krogsgaard, nephews and nieces, Barrie (Whitney) Dunsmore, Lorne (Sharon) Dunsmore, Gary (Brenda) Zerr, Diane (Howard) Johnson, Ken (Bev) Zerr, Doug (Grace) Dunsmore, Brian (Lorna) Krogsgaard, Lindsay (Roberta) Krogsgaard, Joel Dench. Aunty joyfully related to her 23 great and 28 great-great-nieces and nephews. A Memorial Service was held at 2:00 p.m. on Friday, January 27, 2017 at Glen Elm Church of Christ, 1825 Rothwell St., Regina, SK S4N 2C3. Interment at St. Nicholas Anglican Church Cemetery, Kennell District will be held at a later date. In lieu of flowers, please consider a contribution to either Souls Harbour Rescue Mission 3535-8th Ave., Regina, SK S4T 0T6 or to Glen Elm Church of Christ.

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We received this email from Carole Tiefenbach who was a neighbour of Victor Palsson. Victor was a member of Polio Regina but was unable to attend any meetings. We received his membership renewal the day after he passed away.

Victor Palsson

Just to inform you that Victor Palsson passed away April 10, 2017.

He has been a friend since grade school, grew up on a farm right behind our farm in Geysir, Manitoba a few miles from Arborg, MB. He never married, was a sweet gentle soul who wouldn't kill a flea.

He had been sleeping in a lounging chair for quite some time now, due to so much pain, so he is at peace now with a new perfect body with no post-polio!



