
The Biliary Bulletin

Volume 2, Issue 1

Special Millennium Issue

Primary Biliary Cirrhosis (PBC) is an autoimmune disease which affects the liver and for which there is no known cause or cure. This newsletter exists to communicate news and information to members of the Australian PBC Friendship Support Group and other sufferers of PBC.

From Rosemary

Dear Friends

I would like to wish everyone a happy and healthy new year. Let us all hope that this year brings some good results from the people around the world who are working to find the cause and the cure for PBC.

Our group is growing all the time and we are getting to be known all around Australia which is wonderful. We have been contacted by nearly one hundred and seventy people and at the present time we have one hundred and twenty nine members.

This of course is not counting the many people who contact me by email and those who ring for information for other people, usually family members or friends. Our web page at: <http://www.vicnet.net.au/~ozpbc/> seems to be reaching many PBCers, and people can subscribe to our email list from there.

"The Biliary Bulletin" is being given out at many hospitals throughout Australia. I would like to thank all those wonderful doctors for taking the time to inform their patients that our support group exists, you are doing a great job! It is truly amazing where the Biliary Bulletin is now being found.

I am so glad to hear that the contact lists are helping to put many of you in touch, all the people on the list have given permission for their names to be given out so please all make good use of them. It really is so much better when you have others to talk to who have the same illness.

I just wish that everyone interstate could attend our meetings, or that maybe in the future you could have your own meetings in your state. They have all been very well attended here in Melbourne and I am sure we have all learned from them. It also gives us a chance to get together, which is so good.

We are looking forward to our next meeting at Monash University on February 27th, our good friend Dr Ian Mackay will be giving us an update on the Epidemiology of PBC and Amanda Anderson from the Dietetics Department at the Monash Medical Centre will be talking about nutrition in liver disease.

As I have mentioned before, of great concern is the fact that

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many people are not being told about the medication Ursosalk. Time and time again I speak to people who have been diagnosed with PBC but do not know about this medication.

If you are contacted by anyone who has PBC, please make a point of asking if they are taking Ursosalk.. At least people can be given the information about the medication, it is then up to them if they wish to pursue it further.

I would sincerely like to thank all those people who sent me so many beautiful Christmas cards and kind messages of appreciation. I am so glad that our group is helping to provide information and support for PBC sufferers in Australia.. To Jocelyn, a huge thank you for your help and constant support.

Keep positive and smiling everyone, best wishes,

Rosemary

Membership Subscriptions

Members will be reminded when their membership subscriptions are due for renewal, this will fall on the anniversary of the first subscription date, not on 1st March as was earlier stated.

“Overlap Syndromes” *Dr. Katrina Watson*

Most people with primary biliary cirrhosis have a "typical" syndrome - that is, they are usually female (90%); they may have no symptoms or symptoms of tiredness, itch or jaundice; they have typical liver function tests suggesting bile duct obstruction ("cholestatic" liver function tests), they have a positive blood test called anti-mitochondrial antibody (95%) and they have a typical change on liver biopsy.

However, as we have found out more about primary biliary cirrhosis, we realise that not all patients are absolutely "typical"! One variation we seem to recognise more frequently now is the "overlap syndrome". These are people who have some or all features of PBC listed above, but may also have evidence of another autoimmune liver condition as well. It seems that between 10 and 20% of people with PBC may have an overlap syndrome.

The most common "overlap" is PBC and another liver problem called autoimmune hepatitis. People with autoimmune hepatitis have different autoantibodies (they may have a positive antinuclear antibody, or antismooth muscle antibody, or something less common)

They also tend to have "hepatic" liver function tests - this is a rise in aminotransferase (ALT or AST). They may also have an elevated immunoglobulin G test (IgG). People with autoimmune hepatitis will also have different features on liver biopsy.

Thus people with PBC/autoimmune hepatitis overlap may have features of both conditions at once.

Do you need to know if you have an overlap syndrome? Yes you do! Because people with autoimmune hepatitis need additional treatment with immunosuppressive medications like prednisolone or azathioprine. The liver will not improve without these medications.

Such a person will usually also need to take ursodeoxycholic acid for the PBC component of the liver problems.

The treating doctor will be watching the liver function tests to make sure they all improve (the "cholestatic ones, alkaline phosphatase and gamma-GT, and the "hepatic" ones, the AST and ALT). Doctors will often monitor bone density scans, to make sure the prednisolone treatment does not worsen any tendency to osteoporosis.

Some people with long standing PBC can even develop an overlap syndrome after many years - the doctor will notice the transaminases rising gradually. We do not know why some people develop this additional autoimmune tendency and others do not. However, we do know that dual treatment will settle down both problems in the liver, and should prolong the life of that liver.

So it is worth understanding the concept of "overlap" syndrome - so that if it happens to you or a family member, you are prepared, and can take part in treatment decisions with your doctor.

Application for PBS listing for Ursofalk

We need as many people as possible to write to their Federal Members of Parliament asking them to support the application being submitted by Orphan Australia to have Ursofalk listed on the Pharmaceuticals Benefits Scheme.

Many of us are able to access Ursofalk at hospitals at a reasonable price but there is no guarantee that this will continue indefinitely, so please take the time to write to your Federal Member.

Below are the contact numbers to ring for information if you do not know your Federal Member's name or address.

Australian Electoral Commission State Offices

ACT 02-6271-4419

NSW 02-9375-6333

VIC 03-9285-7171

QLD 07-3834-3400

SA 08-8237-6555

WA 08-9470-7299

TAS 03-6235-0500

NT 08-8981-1477

For more information please contact Rosemary

Videos for sale

“**The Kindness of Strangers**” is a documentary type film listening to families talking about their feelings after losing loved ones who have donated their organs to give the gift of life to others. The film also follows recipients, waiting and receiving their gifts and in recovery, a very moving film. Executive Producer Jamie Redford.

UK PBC Foundation Video - Dr Neuberger speaking about PBC and Dr Davis – speaking about Osteoporosis and PBC. Please contact Rosemary for details.

Contact List

We now have about 130 group members and the group is growing all the time. If you would like a list of the other members and their telephone numbers, please contact Rosemary.

Member Profile

Annette Fechner

I was diagnosed with PBC and Sjogren's Syndrome in 1994 age 51. I first presented to my GP with an acute attack of arthritis. My ESR readings were 120 plus. He first tested me for Ross River virus which proved negative, then considered putting me on a course of cortisone, but rang a rheumatologist in Melbourne who said I was too old to suddenly develop rheumatoid arthritis. So I was subsequently booked into the Royal Melbourne Hospital as a public patient where I spent the next 2 weeks having all the X-rays scans, biopsies and blood tests you all are familiar with.

I was eventually diagnosed with PBC and sent home being told there was no cure and no medication, but to return every 6 months for check ups. I left there knowing I had a health problem, but to what extent I really had no idea. My GP said I probably knew as much about PBC as he did. Fortunately my arthritis went into remission, but my LFT's continued to escalate, some into the thousands and others in the high hundreds. My bilirubin was around 38.

I had no itching at this stage but was losing weight and energy and picking up every virus around. I had to have grommets put in my ears after two bad abscesses. Finally my GP referred me to a gastroenterologist at RMH - Prof. Peter Gibson, who is wonderful. He put me on to urso which did help but not as much as he had hoped. He then prescribed me methotrexate, which can also affect the liver, but fortunately it really helped me.

My blood tests improved and I have now plateaued in the low hundreds. My bilirubin is 20 and I have gained weight (nearly too much). I have also developed a wart virus which has been difficult to control, so I have stopped taking methotrexate for the past 3 months in the hope of eliminating the problem. Thus far no new outbreaks. My worst problem at the moment is dry eye, my left eye is badly affected and I have lost some vision. I will be seeing an eye specialist in a few weeks hoping I can get some help.

I live just out of Horsham near to the western highway, half way between Melbourne and Adelaide on a rural property where we grow mainly cereal crops. We also have a few sheep. I am four hours away from Melbourne but have a very caring GP and he is very quickly in touch with my specialist if there is a problem. I have three grown children and 2 grand-

daughters. Both my husband and myself are avid golfers and fortunately I am still able to play at least weekly.

Since developing PBC I have travelled Europe for 8 weeks, had a couple of Bali holidays, and a month last year in the outback of Australia travelling the Canning stock route, and seen the birth of my 2 lovely granddaughters.

I am looking forward to my youngest son's wedding in March. So life isn't all that bad.

Keep positive and smiling it is the best medicine I am sure you would all agree.

Cheers,

Annette Fechner, Dimboola Vic.

Spreading the word

Does your doctor know about us? She/he might know other PBC patients who would like some support. Next time you see your GP or specialist, show her/him this newsletter and ask if your doctor could give it to other PBC patients. If you need more copies – just ask Rosemary.

I'm Fine, I'm Fine, I'm Fine

Poem sent by Doreen

There's nothing whatever the matter with me,

I'm just as healthy as can be.

I have arthritis in both my knees

And when I talk I talk with a wheeze.

My pulse is weak and my blood is thin

But I'm awfully well for the shape I'm in.

My teeth eventually will have to come out

And I can't hear a word unless you shout.

Arch supports I have for my feet

Or I wouldn't be able to walk down the street.

Sleep is denied me every night

And every morning I'm really a sight.

My memory is bad and my head's a-spin

And I practically live on aspirin.

But I'm awfully well for the shape I'm in.

The moral is, as this tale unfolds,

That for you and me who are growing old,

It's better to say I'm fine with a grin

Than to let people know the shape I'm in.

Liver Function Tests *Professor James Neuberger*

Do remember that liver tests are only a guide to how your liver is doing. Interpretation of liver tests must be done within the context of the person's overall condition. It is usually more appropriate to look at a trend in liver tests, rather than taking isolated results. The standard liver tests involve a battery of markers and these are indicated below.

Bilirubin

Bilirubin is mainly a breakdown product of old red cells. The haemoglobin is broken down and carried as bilirubin in the blood to the liver. The liver cells take up the bilirubin and make it easily excretable. It is then pumped through the bile duct's cell into the bile duct itself and then into the bowel. The bilirubin in the bowel helps make it the normal colour and helps absorb a number of nutrients (particularly fats and some vitamins). Lack of bilirubin accounts for pale faeces and the fact that it floats. The floating is due to retained methane rather than the fat (the important message for patients with pale stools is your faeces are flammable and, therefore, smoking on the lavatory is more hazardous!) A high serum bilirubin can be caused by a number of factors including increased breakdown of red cells and obstruction of the bile ducts due, for example, to a stone in the biliary tree. When there is liver disease, bilirubin in the blood may rise either because it has not been taken up by the liver cells, or because it is not being excreted due to bile duct damage. In PBC, a rise in bilirubin is associated with jaundice. This is just the manifestation of a raised bilirubin. The importance of bilirubin in PBC is that it is a very good guide to how badly the liver is damaged and one of the most useful guides to prognosis. In general, the higher the bilirubin, the more damaged the liver.

Albumin

Albumin is a protein that is made by the liver cells. It has many functions in the body including helping to keep the water in the blood vessels, rather than leaking out into the tissues. It also helps carry a lot of important chemicals in the blood. In liver disease, a low albumin is suggestive of liver cell disease (rather than bile duct disease). The serum albumin may be low for a variety of reasons including inadequate intake and loss of albumin through the bowel, skin or kidneys. Therefore, a low serum albumin may indicate liver cell disease, but may also reflect diseases in other systems. In general in PBC, because PBC affects the bile ducts rather than the liver cells, the serum albumin is near normal until the later stages of the disease.

Alkaline Phosphatase

Alkaline phosphatase is an enzyme that is found in the bile duct cells. When these cells are damaged, levels in the blood

rise. In PBC, because it is the bile duct cells that are attacked, levels rise. The level of the alkaline phosphatase in the blood is of little significance, and that the alkaline phosphatase is raised does not really matter. Again, alkaline phosphatase is not specific to the liver and increases in alkaline phosphatase may be due to bone disease (not osteoporosis), rarely, it is due to bowel disease. Sometimes, alkaline phosphatase is increased in pregnancy. However, there is no cause for concern since alkaline phosphatase usually goes up in the later stages of pregnancy and there are better ways of looking for pregnancy than measuring the alkaline phosphatase!

AST and ALT

These are enzymes in the liver cells themselves. They may be called aspartateaminotransferase and alaninaminotransferase, but are usually called by their abbreviations. These enzymes are released when the liver cell is damaged for whatever reason. Again, these enzymes are found in other tissues of the body and, therefore, may become elevated, for example, after a heart attack. In PBC, the AST and ALT are rarely greatly elevated, although levels two to three times the normal range are not uncommonly found.

Gamma GT (GGT)

This is another enzyme that is found in the biliary epithelial cells and it is increased when the cells are damaged. Thus, in people with PBC, Gamma GT levels are high and parallel the rise in alkaline phosphatase. As with alkaline phosphatase, the level of Gamma GT is of little relevance. A number of other factors will also cause increases in Gamma GT, in particular, some drugs and alcohol will also raise levels. Unfortunately, this may reinforce the prejudices of the ill-informed that people with PBC are secret drinkers. Of course, having PBC doesn't mean you aren't a secret drinker!

Prothrombin Time (PT)

The prothrombin time is not a standard liver function test, but it is one of the most useful liver markers. The PT measures the clotting of the blood. There are many different factors that contribute to the speed of clotting of the blood and nearly all these are made by the liver. They have a short half-life and, therefore, changes in the prothrombin time will reflect the synthetic power of the liver. As the liver cells themselves in PBC usually are working normally, the PT is usually normal, or only slightly longer than normal. Prolonged length may reflect malabsorption of Vitamin K. Vitamin K is a vitamin that is fat soluble and so if you do not absorb fats properly (which may occur in PBC people who are jaundiced), the prothrombin time will be prolonged. This can be readily corrected by giving vitamin K either in a different form by mouth, or by injection.

These are only some of the liver function tests. In further contributions we will discuss some of the other blood tests and other investigations you may come across.

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PBC Convention 2000 "Facing the Challenge"

Proudly Presented by the PBCers Support Group

PBC Conference 2000 is our second annual conference event for those who suffer from Primary Biliary Cirrhosis, their family members, friends, other liver disease sufferers and those wanting to learn more about PBC and liver disease.

Our conference is to provide the most up-to-date PBC information on research, treatments, transplantation and our growing PBCers group.

Mark your calendar and join us for an informative and fun weekend.

Conference Fee:

Includes all guest speaker's meetings, group segments, open meeting rooms, 4 scheduled group meals, refreshments in open meeting rooms, gratuity & tax.

Conference fee applies to ALL those who attend ANY of our speaker's meetings, group functions or meals.

\$US120.00 per person if paid before January 31, 2000.

\$US135.00 per person if paid after January 31, 2000.

Fee will not be accepted if correct amount is not sent.

Make check/money order payable to: PBCers (NO cash)

Mail to:

PBCers
C/OLinie Moore
1430 Garden Rd.
Pearland, TX 77581

Conference fees must be paid NO later than April 30, 2000. We will not be able to accept ANY fees after this date or at the conference doors.

Please send in your fee as early as possible, so we will know how many are attending and can make proper arrangements.

Conference fees are 100% refundable if your refund request is postmarked on or before April 20, 2000, and received by April 25, 2000.

Keep in mind, if you find out after April 20, 2000, that you cannot attend the conference, you might be able to make arrangements with another PBCer who was not able to pay their fees in advance and would like to attend.

More information is available at the Convention 2000 website:

<http://hometown.aol.com/pbclasveg/LasVegas.htm>

or contact **Jocelyn**.

A word from the editor

I hope you have all had a pleasant holiday period and that you are facing the year ahead in good health, and with a positive attitude. Remember to laugh often, laughter is a powerful medicine.

I would like to say welcome to all new members. I remember what a relief it was for me to discover others who were travelling the same road as me. Keeping in touch with other members, discussing problems and solutions, comparing notes, all help to get rid of that feeling of being alone and make PBC much more bearable!

This is the fifth issue of the Biliary Bulletin and back copies may be viewed on our website. If you do not yet have a computer or access to one, now might be a good time to start. There is a wealth of information and support 'out there' on the internet.

It would be very nice to have some readers' letters to print. Please feel free to write or e-mail with feedback about our newsletter, or any news or experiences.

I hope that you find the information about the PBC Convention 2000 interesting. I became very excited when I first read it and decided that I would have to go! If anyone would be interested in making up a group with me I would love to hear from you.

The tapes that were recorded at the convention last year by a Queensland member were so interesting and expanded my knowledge about PBC, medication and transplantation enormously. The list of speakers again includes Marshall Kaplan, M.D. whose practice includes a large number of PBC patients, and M. Eric Gershwin, M.D. who is very involved in research into the cause of PBC. These tapes are available from Rosemary.

Some of the articles in this issue have been reproduced from *The Bear Facts*, the magazine of The Primary Biliary Cirrhosis Foundation. We are grateful to them for their permission to reprint these.

Please remember that the material presented in this newsletter is for your information only and that it is important to discuss any changes with your own doctor.

Dr. Katrina Watson wrote the article about Overlap Syndromes specifically for us – Thank you for your support Dr. Watson. And of course a huge thank you to Rosemary for her never ending efforts on behalf of all of us with PBC.

Until next issue, I wish you all very well,

Jocelyn.

Liver Biopsies and Staging of PBC

Professor James Neuberger

Many people with PBC will have been asked to undergo a liver biopsy. There are several reasons why a liver biopsy is requested. The first is to make the diagnosis of PBC and exclude other causes of liver disease. The features of PBC in the liver are well defined and show damage of the small bile duct cells by lymphocytes and other white cells. The pathologist can then confirm that the biopsy does show PBC and exclude other causes of liver damage.

A second purpose of the liver biopsy is to show how much (or how little) damage is being done to the liver. As the damage to the bile duct progresses, there is increasing scarring in the liver which leads to fibrosis. Fibrosis is the result of bands of scar tissue being laid down in the liver, this extends progressively until there is a true cirrhosis.

The normal liver biopsy takes about 1/50,000th piece of the liver. From this tiny fraction of the liver, the pathologist is asked to extrapolate findings to the whole of the liver. In many ways it is like taking, at random, a brick from a house and trying to work out whether there is any damp or other problems anywhere in the house. Because of this sampling, there is always the possibility of sampling variation. The degree of scarring, fibrosis and cirrhosis is broadly similar throughout the liver, but not uniform and, therefore, a single biopsy may lead to wrong conclusions.

Conventionally the liver histology is classified into four stages. There are classification systems in use and they are broadly similar. In brief, Stage 1 represents the earlier stage which is the active destruction of the bile ducts by lymphocytes. At the other end of the scale is stage IV which represents a true cirrhosis. The term 'cirrhosis' is a pathological one and, in my view, the confident diagnosis of cirrhosis can only be made by examination of the liver.

How Important is the Staging?

Whilst the Staging of the liver is of use, it is not that important to the individual patient. It is helpful to the clinicians when

looking at large groups of patients, for example, in clinical studies. Whilst there is little doubt that patients in Stage 1 have less advanced disease than those in Stage IV, the rate of progression between the different stages is variable. Furthermore, as I have suggested above, because of sampling areas, the staging may be misleading. One study done in Birmingham by my colleagues Dr Hubscher and Dr Garrido, took liver biopsies from those livers removed from people with PBC at the time of transplantation. Biopsies were taken from different parts of the same liver and different histological stages were found. Furthermore, features of the different stages could be found within the same biopsy. It is also important to remember that the staging itself is of relatively minor prognostic importance. When the prognosis of a person with PBC is being considered it is, by and large, the serum bilirubin which is the most important prognostic factor. In general, the higher the bilirubin, the more advanced the liver disease and the worse the prognosis.

The presence, or absence, of cirrhosis itself is only of relatively minor importance. For example, if someone is being considered for liver transplantation, the presence or absence of cirrhosis would be unlikely to have any significant impact on the timing of transplantation.

It is therefore, important for the patient as well as the doctor, to place staging in context. It is a useful guide to the degree of scarring within the liver, but it is no more than that. Many people with cirrhosis due to PBC have a very good quality of life and indeed life expectation. Quite a few people without cirrhosis undergo transplantation because the liver is working inefficiently.

I do not think there is a great deal of value in worrying whether you are progressing from Stage III to IV, or II to III, or whatever. The bilirubin will give you the best guide as to how much damage there is to the liver and your own sense of how well you are will give a guidance of your quality of life. Histological staging will not help.

Having said all that, the presence of cirrhosis is of some help to your doctor because there are some complications in PBC which are related to the presence of cirrhosis. For this reason, it may be helpful to know whether or not there is a true cirrhosis, but for reasons which are already stated, it is not as clear-cut as one would like to think.

As always, if there are any doubts or uncertainties, please feel free to discuss this with your own doctor. He or she will be able to give you the best advice and help you interpret the findings of the liver biopsy.

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Computer Corner

John Holman

Got that computer yet? There is an enormous variety of resources for PBCers available on the Internet, including the latest medical research and daily contact via email from all over the world.

Staring for long periods at a screen can be tiring however, which is why the most important (and expensive) part of your system is the monitor. The minimum screen size nowadays is 15 inches (measured diagonally), and if you buy a no-brand computer you won't have to support the jets and limousines of a corporate empire, and can get 17 inches or larger for the same money.

This will enable you to use a higher resolution such as 1024 (picture dots) X 768 (picture dots) instead of 800 X 600 or worst of all, 640 X 480 which is worse than the TV. Higher resolutions fit more on the screen, so you won't have to scroll up, down and sideways to view those World Wide Web pages any more! Resolution is changed with the Control Panel 'Display' applet's 'Settings' tab and Windows calls it the 'Desktop area'. You will also need to choose the 'Large Fonts' option to make text easier to read, and if you have a 'Plus' tab, check for a setting 'Smooth edges of screen fonts' as well, to make text edges less ragged.

Depending how much memory you have on your video card adapter, you will also be able to view up to 16.8 million colours, or 'True Color', depending on the resolution. You may have to settle for 'Hi Color' or 32,000 colours., but anything is better than the standard 256 colours!

Sometimes changing resolution results in noticeable screen flicker. The screen is redrawn upwards of 60 times a second, and many people can perceive flicker up to about 72 times/sec or even more. More video memory and a better quality video card enable much higher screen refresh rates, giving a steady image which is much less tiring on the eyes. Often there is nothing wrong with your video card, the lazy salesperson has merely chosen a 'generic' Windows video driver instead of the one provided by the card manufacturer.

With the latter, there is usually a setting for 'Refresh Frequency' in the Display applet. If you are out of luck, all video card manufacturers provide their latest drivers free for download on the Web, but you may need some technical assistance to install them. (The brand and model of your video card usually flashes on screen when you boot up). It is well worth while to pay attention to your viewing comfort, particularly as you get older – once you have used a well set-up 17-inch monitor you will never return to a smaller one!

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Reflexology – The feet, but not as we know them

Douglas Caird, Reflexologist

Have you ever stopped to think about your feet and just how amazing they actually are? They each contain twenty six bones, over one hundred ligaments and around thirty three muscles. They afford us considerable flexibility of movement, balance and shock absorption in every day situations whilst encased in restrictive footwear.

Yet, despite often minimal attention and frequent abuse, they remain one of the most sensitive and responsive areas of our bodies. Isn't it just bliss to feel the sensations of soaking your feet after a long day, or feel the instant benefits of massage – feelings which affect not only the feet, but the entire body.

Reflexology makes further, deeper use of the feet's natural sensitivity and characteristics, with each foot (as seen through the eyes of a Reflexologist) representing the corresponding side of the body and containing reflex points or zones for all of the body's regions, organs, glands and systems, which when 'worked' by the Reflexologist's fingers, stimulate the corresponding areas within the body.

This stimulation has powerful effects which include subtle dilation of blood vessels to improve blood supply, relaxation of the nervous system and the gentle balancing of the body's

systems towards a desired state of homeostasis – a state of togetherness and harmony between all parts of the body and mind.

It is surprising to find that parts of the feet not normally tender or sore, even under heavy use, can be extremely so under the slightest of pressure from the Reflexologist's fingers. This is often an indication of unbalance associated with the corresponding part of the body through which that particular meridian line passes.

Areas of toxin blockages or 'crystals' similar in make up to those found, for example, on the back during a massage, are often found in areas throughout the foot and can be dispersed during treatment.

Encouraging the body to function as 'a well oiled unit' allows it to cope better with life stresses, illness and natural body functions and changes such as menopause, menstruation, pregnancy, etc., themselves often adversely affected by these stresses and illnesses.

Most people who have tried a session of Reflexology, whether in good health or otherwise, find it extremely relaxing and enjoyable – a pleasant way to maintain well-being at a natural level.

Reflexology is a serious means to facilitate relief and possible

recovery from most ailments and conditions (including as an aid to the body's acceptance and use of other therapies and medications/remedies).

It has a comprehensive case history and is increasingly being regarded by health professionals as a safe and effective therapy in most situations.

Reflexology can also be safely and effectively carried out on the hands and the Reflexologist may also want to work on the face or abdomen as part of a session depending on the client's particular needs.

We all need time out from our everyday activities and we all need some form of caring 'touch'. A touch that allows us to feel that, even if only for an hour, this touch and this time is solely for ourselves – a time to breathe deeply and bring about a calmness within, which can be worth so much and be so special in the context of our individual lives.

Reflexology is not for everyone, but most find it to be a comforting and unobtrusive way to 'take the edge' away from life's pressures and difficulties. Why not be selfish and give it a try?

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