

kiōney Health

NEW ZEALAND

P r e v e n t i o n • S u p p o r t • R e s e a r c h

Winter 2012



Winter has certainly made its presence felt here in Christchurch and we are only half way through!

In spite of that it has been a busy couple of months in our office. I have been fortunate enough to be invited onto a steering committee, together with Rachael Walker from Hawke's Bay, which has met monthly in Sydney to develop a tool that will assist people with end stage kidney disease to choose a treatment option that will be best for them. This project was very interesting, particularly as it highlighted awareness of the factors of perspectives from different parties involved in the decision making (patients, family, practitioners), that may enhance communication and improve the capacity for the patient

and family involvement in shared decision-making. It is hoped that this will increase the number of people choosing to receive their dialysis treatment at home, as research shows many people do better when treated at home, but also ensure everybody has the opportunity to make an informed choice. We hope to be able to pilot the tool when it is completed here in New Zealand towards the end of the year.

I have had several speaking engagements recently, with a variety of groups ranging from U3A groups, Probus and nursing students. We attended a health information day at Aranui High school, a low decile school here in Christchurch, where we provided kidney health checks for staff, students and members of the public.

I was fortunate enough to attend the 40th Renal Society of Australasia conference in Melbourne in June, although due to the snow I missed the first day, my report follows Anita's story in this newsletter.

Meanwhile Kelvin has almost completed updating our popular resource "Living with Kidney Failure" book, we hope to have this at the printers within the next few weeks. It will have a new look and new names to represent the changing face of kidney disease treatment. We are about to commence work on three more web based resources for the Ministry of Health, more on this in the next newsletter.

On Saturday July 28th we are holding a Kidney information Forum here in Christchurch in conjunction with the Christchurch Kidney Society. It will be held in the Govan room, on the 2nd Floor of the Don Bevan Medical Research building at 40 Stewart Street. This forum is open to the public. Please call me on 0800 543639 for further information.

In August Kelvin and I are attending the Australia and New Zealand Society of Nephrology conference, being held in Auckland, where we will have a stand to promote our work and raise awareness of our resources.

Our Facebook page has received a number of views and comments as we post items of interest. Of particular interest currently has been the fact that New Zealanders can now state on their Facebook profiles that they want to be organ donors.

Anyone who wishes to be an organ donor can do so by creating a life event on their timeline, and if they want can share why they decided to be a donor. This allows people to share this important information with their family and friends and increase awareness and conversations around organ donation. I have had several calls on the 0800 line on this subject already.

The move follows similar schemes in the US, Britain and Australia and comes with the approval of the Ministry of Health and Organ Donation New Zealand.

The following pages cover a variety of topics in the kidney world, I always welcome your feedback.

Carmel Gregan-Ford

An inspirational story



Outram woman Anita Lloyd celebrates 25 years with a kidney transplant.

To celebrate 25 years with her donated kidney, Outram woman Anita Lloyd took it home to Wellington. She always had a "rough idea" the organ that made a "huge difference" for her was from the capital. With friends and family, she celebrated the occasion there earlier this month, wearing specially-made T-shirts.

The "lucky third" kidney transplant she received at the age of 19 followed two failures: one lasted a only month, and the other just two years. Her 1987 transplant pre-dated live donations, meaning her kidney came from a dead donor. "I would love to thank the donor family. They were struggling with losing someone they loved. "They made the decision to donate, which saved my life. "Thank you is not really enough ..."

Before the anniversary, she asked Dunedin's "super" nephrology department for an ultrasound of her kidney, which she used to make personal cards to thank people, including the doctors in the department.

She could "count with one hand" those she personally knew around New Zealand whose transplants lasted 25 years or more. There were also one or two recipients whose transplants were going strong after more than 40 years.

Organ failure was common, requiring constant monitoring for signs of deterioration. "It's never out of the back of your mind that one day it will fail, because it's not meant to last forever," Mrs Lloyd said.

She had been surprised by how many approaches the special T-shirts attracted in Wellington, mostly from people who knew someone with a transplanted kidney.

Many were surprised her transplant had lasted so long, and it was good to give people hope for the recipients they knew, she said. She urged people not to consider themselves donors if they had "ticked the box" on their driver licence. It was always a family decision, and something people should discuss beforehand.

Mrs Lloyd said her transplant gave her a life which bore "no comparison" with having to endure regular dialysis.

From the Medical Director

Important Australian study shows that dialysis patients and their families prefer home dialysis

Patients with severe chronic kidney disease may be treated with kidney transplant, dialysis, or conservative/supportive therapy. In Australia and New Zealand in 2009 patients starting treatment for kidney failure had haemodialysis (69%), peritoneal dialysis (26%) or a transplant (5%) as their first treatment. In the past the choice of starting treatment was influenced by what treatments were available locally, your doctor's opinion and your other medical problems. The importance of patient and care giver preferences has only been recognised relatively recently. As there is little difference in survival or quality of life between peritoneal and haemodialysis, patient and care giver preferences should be given proper attention. There has been a resurgence of interest in home dialysis in a number of countries. Home dialysis has several potential advantages over centre dialysis, including less travel to the hospital and no time lost in waiting at the hospital for a treatment session to begin. People on home dialysis also have more flexibility regarding the timing or length of dialysis sessions.

Dr Rachael Morton, a health economist from the University of Sydney who has an interest in chronic kidney disease, and other Australian kidney researchers surveyed 105 predialysis patients and 73 family caregivers about the type of kidney failure treatment they would most likely choose. The patients were asked to choose a type of treatment from different sets of choices based on information such as the average survival time, hours per treatment, and number of hospital visits required. The options were home haemodialysis, peritoneal dialysis, centre dialysis and conservative/supportive therapy.

The study found that home-based dialysis (either peritoneal or home haemodialysis) was chosen by patients in 65% of choice sets, centre dialysis in 35% and conservative care in 10%. For caregivers, this was 72%, 25%, and 3%, respectively. Both patients and caregivers preferred longer rather than shorter hours of dialysis but were less likely to choose overnight than daytime dialysis. Patients were willing to forgo 23 months of life expectancy with home-based dialysis to decrease their travel restrictions and caregivers 17 patient-months. Patient age, sex, and distance from home to the dialysis unit did not significantly affect their choice of type or place of dialysis treatment. Nearly three-quarters of the care givers agreed with the statement "I would prefer my family member with kidney disease to dialyze at home."

The authors noted that "Our results suggest that extended-hours dialysis (eg, 8 hours of haemodialysis) would be acceptable to many new patients, particularly if extended hours produced a survival benefit" and that "home-based dialysis that enabled patients and their

family members to travel with minimal restriction would be strongly aligned with the preferences of both parties.”

Kidney Health New Zealand is committed to supporting patients, care givers and health professionals in making treatment choices. KHNZ does this by the provision of patient information (in print and on line), education of patient support groups, funding of research and support for the professional development of health professionals.

Chronic kidney disease is common, harmful and treatable.

Professor Kelvin Lynn, Medical Director of Kidney Health New Zealand

Renal Society of Australasia Annual Conference 6th – 9th June 2012

Below is my report from the conference, unfortunately due to my flight from Christchurch being cancelled because of snow I missed the first day of the conference.

Professor Merlin Thomas. Diabetes and CKD.

A Common Problem worldwide

Diabetes is a growth industry in Australia, there will be no shortage of diabetes disasters coming through the door in the coming years

Of the 20,000 diabetics seen by Drs over half had CKD, which essentially means that every second patient has CKD

Professor Thomas made a very good point when he said “Chronic Kidney Disease should have the word kidney taken out to get government to notice” as kidney disease is often seen as a secondary disease and as a consequence receives little recognition in the Chronic Disease funding.

It really is the most important endocrine gland in the body

As we all know ESKD has a huge impact in terms of heart failure, anemia, quality of life etc

Data out of Finland with type 1 diabetes saves lives in Finland because they have an excellent health systems, without diabetes do less well!!!

Diabetes on its own not a killer, but with kidney disease it is.

Professor Thomas described Kidney disease as a Sysiphean problem (In Greek mythology Sisyphus was a man who had defied the Gods so his punishment was to push a rock up a mountain; on the top, the rock rolls down again and Sisyphus has to start over. Prof Thomas uses Sisyphus's ceaseless and pointless toil as a metaphor for dealing with the problem of diabetes and kidney disease. Essentially it's hard to get BP control, it's hard to get glucose control etc and often feels Sysiphean. But working hard at getting blood sugars under control is the solution to reducing ESKD.

Hypoglycemia incidence risk factor in renal dysfunction. Endocrinologists don't know insulin half life is extensively prolonged in renal impairment, so often this can create further problems in treatment.

There is some light on the horizon for some;

“Dawn of the Gila monster” who lives in the Sonoran desert (home of the Pima Indians) Pima Indians are known for their high rate of diabetes, many end up on dialysis. Age of diabetes is getting younger in the Pima Indians - this is a microcosm of us as this will eventually happen around the world.

The Gila monster eats once every 1-2 months up to 1/3 of its weight and never has a hypoglycemic episode. Glucagon is released when you start to eat. The human version lasts a few minutes whereas the Gila monster saliva version lasts hours. This slows metabolism, reduces hunger and controls blood sugars. Exenatide is a synthetic version of a protein, exendin-4, derived from the Gila monster's saliva reduces hypoglycemic episodes by increasing incretin levels. The effectiveness is due to the fact that the lizard protein is about 50 percent identical to [glucagon-like peptide-1](#) analog (GLP-1), a hormone released from the human digestive tract that helps to regulate [insulin](#) and [glucagon](#). The lizard protein remains effective much longer than the human hormone, helping diabetics keep their blood sugar levels under control. In a three-year study with people with type 2 diabetes, exenatide led to healthy sustained [glucose](#) levels and progressive weight loss. This is an exciting development. Injectable form of Gila monster venom only needs to be given monthly to diabetics.

Another drug Baradoxolone has been found to improve kidney function in patients with type2 diabetes and CKD, studies show it increases GFR by up to 10 Mls per min, It is currently being trialled in Australia.

Zaidee's Story - Allan Turner

Allan's 7 year old daughter Zaidee died of an aneurysm in 2004, she saved 7 people's lives when the family made the decision to donate her organs.

She was the only child to donate organ and tissue in Victoria that year. Allan and his wife were shocked at this statistic and decided to make it their mission to increase the numbers of people donating organs, by raising public awareness. The following year 5 children donated, after the family put up a plaque and photo of Zaidee in the paediatric ICUs.

Hawthorn and Port Adelaide AFL teams play for an annual trophy to raise awareness of organ and tissue donation. Flags with Zaidees pic and the rainbow symbol waved at matches. Rainbow laces on a footy ball, rainbow colored footy shoes. Rainbow shoe laces are given out, there are bags of Zaidees apples and Zaidee's rainbow sweets can be found in stores throughout Australia

140,000 died last year in Australia and of these only 337 were donors

There are 50 children on a waiting list and 1600 people waiting for organs in Australia.

National schools online education programme starts 1st July, over next 3 years about 2 million children will be exposed to information about organ donation

Where did the idea of using a rainbow as the symbol for Zaidees campaign, Zaidee was 7 when she died, there are 7 colours of a rainbow, 7 days in a week, and Zaidees shoes had rainbow coloured laces in her shoes when she was little, which she loved.

Raising awareness of organ donation - Nicola Stitt

In 2009 Commonwealth organisation committed \$151 million over four years to maximize access to organs and tissue transplantation in Australia.

All States in Australia have committed to the project, it is known as the Donate Life Network.

Highest donation rates have occurred from 2009 to 2011, with strong growth. 337 donors with 1041 people receiving a transplant. More families are being approached in hospital by staff re donation.

Mid point review gives hope to achieving 16 donors per million by end of 2012.

Some of the methods being used include;

- Expanding donor pool - donation after cardiac death, suitability criteria becoming more lenient. Risk of transplantation versus not getting a transplant. Upper age limits for some organs increased
- GIVE clinical trigger (have you given your patient the opportunity to GIVE) This is a tool used to help staff identify potential donors
- Increasing consent rates, about 60% in an Australian audit agree to donation. If request made by someone knowledgeable and supportive about donation this has been found to encourage donation.
- Raising awareness - like NZ many don't discuss organ donation as a family. OK to Donate great website www.donatelife.gov.au

Priorities for targeted education programmes, especially for ethnic communities.

Shinto and Gypsy Roamny religions are the only ones to be against organ donation known in Australia.

Working together for Change - Rachael Walker

Rachael talked about the CKD pilot study currently happening on East Coast of New Zealand.

Purpose - screening and managing high risk CKD patients in primary care

Two primary care practices chosen in poorest areas on the East Coast

Targeting reduction in ACR, BP, HbA1C, Chol, lifestyle modifications.

Working predominantly with Practice nurses and some GPs

"hard to reach patients" mostly involved.

Initially one of the key focuses was finding out what the patients actually knew about their condition

2 week follow up after initial visit the followed by 3 monthly reviews

Diabetic, hypertensive with albuminuria were the targeted group.

The sample group was made up of 71% Maori, 19% Pacific, 10% NZE

90% of those targeted were clinically obese.

Results - ACR significant improvement

BP dramatic decrease

HbA1C harder to manage, but big improvement.

BMI a small difference only esp at 9 months.

CVS risk minor changes

Some of the findings included;

- All results tapered off a little after 9 months.
- Knowledge change very much improved also lifestyle change improvement
- Intensive nursing management program is effective
- Benefits in partnerships with GPs, PN and Pharmacists.
- Majority of patients are making significant health changes.

The low clearance clinic - Jennifer Best

Patients being seen by different nephrologists meant lots of different plans and inconsistent advice. Consultants not always aware of patient treatment plan, as a consequence of these findings it was decided a change in the model of care was needed – with a more focussed multi disciplinary approach vital, so the Low Clearance Clinic evolved.

The changes made included

- Nominated consultant for patient load,
- Pre dialysis nurse sits in on clinics to ensure continuity.
- Increase support from pharmacist, dietician, social worker
- Plan to have a diabetic educator in clinics when required.

Aims of the clinic are to, improve timely access creation and increase uptake of home dialysis therapies.

Results: 82% of patients started home therapies, patients experiencing better outcomes.

And a more formalized treatment plan has been developed with buy in from all staff.

Quality Assurance - Linda Ball USA

Linda talked about the benefits of quality improvements. Simply put it examines processes in order to improve them. Some of the benefits include;

- Improve pt survival
- Employee satisfaction
- continuity of Care
- Decrease costs
- Profitability

It is quite different in the US

Do it right the first time. Payment based on quality based on points for a variety of things, points are allocated for fistulas and points are lost for catheters. Values are being assigned for almost everything. Depending on points depends on funding from Federal Govt.

Patient anger and aggression- David McCallum

Royal Melbourne Hospital Care Service decided to run workshops following reports of an increase in patient aggression

Renal social workers ran workshops around

- Causes of anger
- How these were managed
- Effect of the work environment

In 2008 it was noted there was a big jump in anger and aggression incidents, as a result the unit policy was reviewed, identifying risk factors. "Riskman" - an electronic reporting tool for all risk management events was utilised

The most common timing of events was usually waiting times between coming off and going on to dialysis.

Staff were educated and a pathway to deal with these situations was developed.

Reviewed patients rights and responsibilities brochure.

Since review there has been a significant decrease in incidents and up until June 2012 there has been no reports of anger and aggression incidences.

RENEW Project: John Harkness

Why change?

Struggling to meet demand

We know home therapies as very effective but only 41% on these(aim is 50%)

Stakeholder consultation very important.

Per dialysis planning process - patient journey/ perspective and staff perspective

Coordination and integration of care very important and a common theme with both patients and staff.

Solution design to address problems identified

Home haemodialysis nurse introduced

Developing an integrated management system specific to haemodialysis - Samantha Tan

RiskMan. Net can be accessed simultaneously by all nephron care clinics, it allows for reporting of hazard Identification

Equipment failure

Staff incidences

Patient adverse events

Complaints and feedbacks

These reports are sent to the management of Nephrocare for action as required, this enables a more efficient response To identified incidences.

Review of reports in 2011 it was noticed there were several hypotensive events, the procedures were reviewed and adapted as necessary resulting in a decrease in hypotensive events.

John Agar -Green Dialysis

While clinical services and their staff have been trained to diagnose, treat and care for those in ill health, they have not been trained to think about the environmental "fall-out" of their treatment practices. Commonly, little thought is given to the holistic carbon footprint we leave behind. This being the case John Agar is looking at and initiating ways in which we can be more "green"

Some of the problems for dialysis units include; mains water greedy, grey water wasteful, power hungry- Carbon footprint heavy, utility costs becomes a patient expense when we send patients home.

In Australia patients pay their own utility costs

Units need to be far more responsible for water usage

Power costs are set to double or triple over next 5 years

Need to find ways to sustain patients at home.

Waste disposal is a big issue and need to develop systems to reuse and recycle

Need to be Eco responsive, carbon footprint light

John showed the Fresenius building of the future, which had some very innovative features

- Reject water quality is easily drinkable 1 litre per minute goes down the drain during dialysis. 490 L of water is used per patient per treatment.

- 350 litres of water wasted per treatment.

In Geelong they reclaim reject water, which is used for autoclaving, flushing toilets etc in the hospital.

In home system, water tanks, pump to cattle troughs, laundry reuse systems, gardening watering system.

Growing seaweed from dialysis waste (John Agar using this in Geelong)

In Geelong there have been innovative water systems installed into 8 home dialysis patients.

Reusing Reject Water is community minded, inexpensive and "good media"

The water saving volume and cost is profound; cost reductions at home may encourage retention rates.

Potential for generation of income (sell onto local car wash etc)

Solar power assisted dialysis feeding solar power to the national grid, and use power directly from the national grid. It cost \$16,219 Au to install solar system of the roof. Power reduction 76.5% and cost saving.

Some ideas that are being looked at are incentivization action for home patients - discounted home solar for all home patients, it will cost around \$3400 to set up solar system Overseas groups;

www.greenerhealthcare.org/green-nephrology

Green nephrology (UK)

Is staffed

Resourced by the NHS

Has a significant publication record

Has mapped the complete carbon footprint for dialysis, to reduce the environmental burden of dialysis.

Info@sustainable.healthcare.org

Some of the ideas for use of recycled waste include

- 2.5 kg per treatment of waste - on site autoclaving of dialysis waste products, using reject water to drive the autoclave.
- Road bollards used made from reused plastic waste from dialysis lines.
- Using roof spaces for gardens, perhaps patients could tend their gardens on the roof after they finish dialysis!!

John also talked about the issue of light in dialysis published in clinical chemistry - interesting research into the effect of light during dialysis treatment

Findings light shielded patients had lower plasma concentrations. The environmental light that shines on the blood lines..... Hour after hour, might actually matter!

History of Haemodialysis in Australia and New Zealand - Bill Adams

1967 haemodialysis was a big procedure, all gowned gloved parading around the patient and a recirculation tank

Peritoneal dialysis was a continuous and endless with flow rates being limited by an inline millipede filter.

In 1968 there was a very low medical and public awareness of dialysis in the community

The AV scribner shunts were used. The AV fistula which was developed in the mid 1960 s was only rarely used.

Keel dialyser plates were reused a number of times for each set up. It took a long time to set them up, making haemodialysis a very cumbersome and laborious procedure

Dialysis staff died from Hepatitis which they caught from patients

1978 was the first time ANZDATA information gathered, in it's crude form

1977 the common causes of renal failure were Glomerular Nephritis 35% , Analgesic Nephropathy 17%, renal failure from diabetes very low back then!

The girl with the Butterfly rash- Kathy McNamara

This was a case study

27 yr old female with SLE diagnosed at 14

Developed cerebral lupus in 2012

SLE affects females more than males 10-1

It affects skin, kidneys, blood, heart, CNS,lungs

ANA antinuclear antibodies have the ability to attack structures of the nucleus of the cells

Raised ANA levels found in SLE

She ended up developing lupus nephritis, which was managed with medication and is currently in remission.

Renal palliative care program-Samantha Harrington

Chronic Diseases Palliative Care project, funded by government

Northern Territory renal services have 71% of their patients live in remote areas

85% of all people receiving dialysis in NT are aboriginal

Use of aboriginal interpreters is integral to service

Model of Palliative Care, they want to go home to have Bush Tucker, tell their stories, be with family and friends.

Coordinator role encourages patients to be referred when GFR is 15

Talk to family about kidney disease, what it means how important it is to take medication.

The chief objective is to try to get people home so they can die there.

Specialist Outreach clinics have been set up

Teleconferencing a great tool for communicating with family regarding the plan for the family member

Staff from the Palliative care team talk to clinics about their service seeking feedback on how they can improve it.

The most important aim is to enable quality time with their families before they die

It is important that clear concise information about palliative care is given to the patient and their family

NT govt funds "Return to country flights", this is where the patient is flown back to their home to die.

Challenges

English as a second or third language

Decision making hierarchy

Cultural issues around death and dying

High turnover of staff

Outcomes

Improved continuity of care

Educational materials developed

www.kidneyheathaustralia.org.au. Have all the resources on line.

Improving outcomes for patients with ESRD -Charlotta Ekatrom

Sir Charles Gardiner Hospital WA -CKD clinics

Had 80-90 pts commencing dialysis annually of these 70% were late referrals

So.... Increased FTE pre dialysis educator role

Focussed on what is CKD, symptoms, Self management, treatment options. The result being an improvement in the numbers of late referrals and better relationships with GPs

Renal Supportive Care - Elizabeth Josland, St George's Hospital

Another talk about the palliative care role with the increase in age of those commencing dialysis, which of course brings with it it's own set of issues.

Maintaining good links with palliative care team seen as important

Working with other disciplines, as well as social workers and pharmacists

Continuity of care important for the patient and their family.

PD in a Multicultural Society Fiona Brown, Monash Medical Centre

Population of Australia breakdown

88 %Caucasian 73% PD

8.1 %Asian 15% PD

2.3 %Torres strait/ aboriginal 7% PD

Asians have better survival rates on PD

Why?

?Smaller

?Dietary habits different, less constipation

?Less glucose

?Better RRF

?Better compliance

?Less systemic inflammation

?Genetics

?Low transporters

No increase in (PD or HD) Aboriginal combined mortality but significantly increased in transplant mortality compared with Caucasian

Poor PD patient survival in aboriginals from regional and remote regions.

Aboriginals have higher PD peritonitis rates

Asian countries have 96% technique survival vs 50% in Australia

QOL is lower in Asians than others on dialysis, not entirely sure why this is

Basically Asian patients do better on dialysis, Indigenous patients do worse.

Cultural Considerations in a Renal Diet - Karen Manley

A good diet will improve nutritional status and outcome.

Group education not ideal as everybody is different in what they do and don't like

Issues include; understanding, lack of support, religion, lack of resources, aim of treatment, lack of communication

Make sure they can read, some patients don't want to admit they can't read.

Cultural attitude to diet eg Japanese starve during illness, Italians eat more during illness.

Culturally based food habits are often one of the last traditions people change because they preserve ethnic identity.

I am often asked how can I help someone I know has a chronic illness, here are some simple ideas shared by Christine Miserandino

You do not need to spend a lot of money. You can be thoughtful in so many ways. The point is to do something, and do something today. I have listed below some easy ideas that anyone would appreciate. Sometimes it is hard for a patient to ask for help. **Just do it!** The hardest thing about chronic disease is that it is chronic. I had a friend who had a really bad flu and she received flowers that very week. With me – since I am sick all the time... I get nothing. Am I any less sick, sad, frustrated, lonely, or bored. **NO**, I need your love and support now more than ever. When everyone else forgets that I am still in this struggle with my illness..... please remember. It didn't go away, I didn't forget. I need you to be my friend.

- A box of pretty note cards and have them all be pre- stamped- this way the patient just has to write notes to whoever they want, and they have everything write there.
- Send a care package. Get a box and fill it up with goodies. Remember how you felt at summer camp when you got a surprise package? It was so much fun to rip it open and see what was inside. Nothing has to be expensive, you can go to the dollar store and get fun little things. The idea is just to make the patient smile. Tip: I have always liked when people have written in a note “No thank you necessary.” I get a gift without the guilt of wanting to send a thank you note.
- Happy nothing! Sometimes we only send our loved ones flowers or get well gifts when they are actually in the hospital or when things get particularly bad. But I think that makes the patient only feel love or attention when things are horrible. Do things really have to get that bad to be a good friend? If you love them today, show them today. If you can, send a bouquet of flowers just to brighten their day. There are so many gift delivery companies online that can send a wide variety of gifts. Every day is a struggle when battling a chronic condition, or going through lengthy medical treatments. Maybe you can make this day a bit better. Don't wait for a reason, making your friend feel better and surprising them is reason enough. Who knows? You may just brighten their whole outlook and turn their day around.
- Help with regular every day tasks. When I am sick sometimes I am overwhelmed with the every day jobs or errands that I no longer have energy for. One of the best gifts I have gotten is when friends or family have offered to help me for 1 hour to do anything. Just having company helped make the time pass and helped encourage me to do the jobs I probably couldn't do before. For example, in the change of seasons going through clothes or straightening your closets can be a daunting task, but if you help while your sick friend lays on the bed, then you can get the job done, feel organized and talk too.

We remember

Allan Sycamore

Allan was a stalwart of the Southland Kidney Patient Support group, he helped set up the group and worked hard, along with his equally hardworking wife Hazel, to provide support and information for people with kidney failure in the region. He will be missed by us all. Our thoughts are with his family. R I P Allan.