

Volume 6 Issue 3

February 2006

HAPPY VALENTINE'S DAY EVERYONE!!

Dear Elders Workers,
Please don't forget to follow-up on the yearly Invoices for \$250, one-way or another, as your help is definitely needed to keep this all going for our Elders in BC. Gilakasla, D. Stirling



MOCCASIN HOCKEY TOURNAMENT

Once again the Quilchena Braves Hockey Club will be hosting the 37th Annual Moccasin Hockey Tournament here at the Nicola Valley Memorial Arena in Merritt, B.C. Tournament dates are February 11 and 12, 2006

The moccasin tournament is one of the social events around the Nicola Valley, people travel from great distances to cheer their favorite team, visit with their friends, and just have a great time.

(The moccasin tournament is open to any aboriginal team)

So, people out there, do plan to attend this great hockey tournament.

For further information please contact;
Dan Manuel at 1-250-350-3369
Tim Manuel at 1-250-350-3379
Buzz Manuel at 1-250-350-3379

BIRTHDAY WISHES

Happy Birthday wishes to my sister Mary Peters on Feb. 1st; my brother Eugene Alexander on Feb. 4th; and to my brother Peter Alexander on Feb. 17; best wishes throughout the year to all of you.
Love Lena, Bridge River, Xwisten

BC ELDERS COMMUNICATION CENTER SOCIETY

ELDERS VOICE

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Easy Bakers Corner – Kahlua Mousse - serves 4

Beat 2 egg yolks and 2 Tbsp. of Kahlua in the top of a double boiler. Beat in 1/4 cup of sugar and beat until slightly thickened and color lightens.

Place pan over boiling water. Cook and stir until thickened, about 10 minutes.

Set top of double boiler in a bowl of cold water. Beat until mixture is thick, 3 to 4 minutes.

Melt 3 oz. of semi-sweet chocolate and butter together. Stir in remaining 2 Tbsp. Kahlua. Add to egg mixture.

Beat the 2 egg whites until soft peaks form. Add 1/4 cup of sugar. Beat again until stiff peaks form. Add to chocolate/egg mixture.

Spoon mousse into parfait glasses or dessert cups. Chill 3 hours before serving.

Handy Tips: 1. Oil on blouse—saturate with WD-40, let it sit for 15 minutes, apply dish soap, rub in gently and rinse, then wash as usual. 2. Nail polish on clothing, spoon acetone over the polish till it dissolves (place the area of cloth over a bowl with an elastic band to hold it in place so you can spoon the acetone over it without stressing it). If the material is delicate, use a non-acetone remover. 3. Armpit stains, dip stain in 6 to 10 dissolved aspirins in warm water. Soak for 30 minutes and wash as usual. 4. For blemishes, use Milk of Magnesia, dab on with a cotton ball, let sit overnight, and repeat for a couple of nights as needed. 5. Always pat dry your hair and comb it out with a wide toothcomb from the ends first to help avoid tangles and breaks.

What Can you please share?

The following is a short list of Elders suggestions of what might be shared: Your local Newsletters/Upcoming Local Events/Prayers/Poems/Quotes/Comments/Photo's/Storytelling/Drawings/Articles of Interest/Native Songs Lyrics/Wellness Seminars/Obituaries/Birthday Wishes, etc. **Articles/Submissions are best forwarded to me via email** where possible so they can be posted on the website as is. If you are interested in providing articles, please do, I look forward to hearing from anyone who wants to contribute to the content. D. Stirling

'PRESERVING THE PAST'

New Elder's Website: www.bcelders.com

The *First Ever* Elder's Website "Preserving the Past" is now online (Sept. 2002). Future registration forms, booth forms, maps of the Hosting territory, accommodation information, etc. concerning the Annual Gatherings will all be available on the B.C. Elder's Communication Center Society's Web Site at www.bcelders.com as soon as they are made available from each new host community.

Issues of your Elders Voice Newsletter are posted on the website each month (though all issues still continue to be mailed out to your Elder's Contact People throughout the province - to ensure that no one is left out because of a lack of access to the internet).

Comments? Please feel free to call in to the Communication Center - contact info is on the back page

Disclaimer:

Health articles, etc. are provided as a courtesy and neither the BC Elders Communication Center Society's Board/Members or anyone working on its behalf mean this information to be used to replace your doctor's and other professional's advice. You should contact your family physician or health care worker for all health care matters. Information is provided in the Elders Voice for your reference only. And opinions contained in this publication are not those of Donna Stirling, Coordinator unless her name appears below the material.

30th ANNUAL BC ELDER'S GATHERING

Hosted by

Nuu-Chah-Nulth Tribal Council and Tseshaht First Nation

July 18, 19, 20, 2006

**Alberni Valley Multiplex,
3737 Roger Street, Port Alberni, B.C.**

For information please contact:

Coordinator: Vina Robinson

Office # 250-724-5757 Fax # 250-723-0463

Email: vrobinson@nuuchahnulth.org

Accommodations:

Best Western Barclay Hotel 1-800-563-6590

Coast Hospitality Inn 1-800-663-1144

Somass Motel 1-800-927-2217

Tyee Village Motel 1-800-663-6676

Timberlodge Motel (250) 723-9415

Redford Motor Inn (250) 724-0121

Greenport Hotel 1-877-463-0333

*****Dear Elders and Workers, please mention the Elders Conference when you call these hotels to access the rooms that Vina has kindly had blocked-off for your event, or they will likely tell you that they have no vacancies. D. Stirling**

First Nations Leadership Council Seeks Constructive Relationship With New Conservative Government

Coast Salish Traditional Territory/ Vancouver, B.C. - The First Nations Leadership Council is looking to establish a constructive working relationship with Prime Minister elect Stephen Harper in the wake of a Conservative minority victory. In a letter sent today the Leadership Council congratulated Mr. Harper and requested a meeting during his first official visit to British Columbia as Prime Minister.

"For now, we must put aside our concerns and work to establish a new relationship of trust and cooperation with the Prime Minister and his new government," said Shawn Atleo, BC Regional Chief of the Assembly of First Nations. "We have our priority issues and are confident once we have had the opportunity to meet with Mr. Harper, we will reach a mutual understanding of the required actions on key Aboriginal issues."

The letter also encouraged the Prime Minister-elect and his minority government to work collectively with the other federal parties to ensure Aboriginal issues are given the high priority and attention they deserve.

"We are confident Mr. Harper will honour the historic government-to-government accords signed between First Nations and the Government of Canada at the conclusion of the First Ministers meeting in Kelowna in November. " added Chief Stewart Phillip, President of the Union of BC Indian Chiefs. "We will also be seeking meetings with all Opposition parties to ensure they fully support the implementation of both the Kelowna Accord and the BC Transformative Change Accord."

"We are encouraged by Mr. Harper's pre-election statements, which promised his party would proceed with the residential school agreement and recognize the contributions of Aboriginal veterans. We look forward to speaking with him about these and other key issues, including the federal government's \$5.1 billion commitment to enhance the lives of Canada's Aboriginal people and the resolution of the land question in for First Nations both within and outside the BC treaty negotiations process", said Dave Porter and member of the First Nations Summit Political Executive.

-30-

The First Nations Leadership Council is comprised of the political executives of the First Nations Summit, Union of BC Indian Chiefs and the BC Assembly of First Nations. The Council works together to politically represent the interests of First Nations in British Columbia and develop strategies and actions to bring about significant and substantive changes to government policy that will benefit all First Nations in British Columbia.

For more information:

BC Regional Chief Shawn Atleo, BC AFN (604) 220-5822

Chief Stewart Phillip, UBCIC, (250) 490-5314

Dave Porter, FNS, (604) 926-9903

The UBCIC is a NGO in Special Consultative Status with the Economic and Social Council of the United Nations

November 25, 2005 First Ministers' Meeting, Premier's Closing Remarks

First, let me again acknowledge the Westbank First Nation and the Okanagan Nation for welcoming us to their territories. Let me thank the chiefs and elders who came and shared their stories and worked with us through the last two days.

The contributions of this forum will have an impact on the lives of hundreds of thousands of Canadians – Aboriginal Canadians, First Nations, Inuit, and Métis people.

It has taken us 138 years as a nation to arrive at this moment. It has taken decades of dialogue and a tortured path of frustration and failure to bring us to this moment of clarity and commitment.

The commitments each of us have undertaken at this table are profound, far reaching, and fundamental to the Canada that we all aspire to build together.

Like everyone, I sincerely hope this moment will prove to be a pivotal moment in Canada's future.

For me, it has been the single most significant, poignant and promising act that we have been able to accomplish together.

As with the prime minister and the federal government with each of the provinces and the territories and with the five national Aboriginal organizations, we have set a path for the future which I believe Canadians will embrace.

I would like to thank all of the premiers who spent a great deal of their time working towards this meeting, reaching out to their Métis, Inuit and First Nations leaders across their provinces and territories so that we could come here today with the fundamental shift in direction and a fundamental change in the relationship that we all share.

Minutes from now, this table will be empty. This room will be cleared. There will be silence.

Our job now, and our abiding commitment to one another and to the citizens we serve, is to ensure that the memory of this moment finds its voice and its force in history through our actions, through a new working relationship aimed at ensuring Canada's third solitude is henceforth recognized as a true founding partner in confederation, and through an action plan back-stopped by ongoing political commitment, genuine partnerships, and new funding to bridge the gaps for aboriginal children, families, and future generations.

Our duty now is to ensure that when this room goes dark, the light that has been lit, the light of hope that has been lit over the last two days, lives on and burns brighter, month after month, year after year in our hearts and in Canada's corridors of power.

Mr. Prime Minister, the honour of the Crown depends on our meeting these commitments. The honour of the Crown has been the silent partner in this room here and now. And with our words, its import is at stake.

I want to stress that from British Columbia's perspective, the honour of the Crown is the ultimate guarantor that we will leave this room with. We will enter a new era of respect and accommodation and reconciliation.

Jurisdictional overlaps or uncertainties must not be an excuse for inaction. We must not allow them to stand in the way of what we know is right to do.

Real progress on each front we have contemplated must be made. Constitutional wrangling must not become a refuge or an apology for inaction.

All of us at this table today are the leaders who must now take these new tools and get the job done. We're the leaders who must respect and embrace the explicit commitments and assurances that we have made to Aboriginal leaders and citizens across this country.

We're the leaders who will be held to account for making meaningful progress in health, education, housing, economic development for First Nation, Métis and Inuit people across Canada regardless of where they live.

The world looks at Canada and they aspire to be like Canada. They aspire to the model that Canada has set. A model of harmony, tolerance, understanding, cultural diversity and unlimited potential and promise.

Yesterday and today, we have looked at some of our failings as a country and we have embraced the idea that we can improve; we can be better. We can be better for all Canadians and we will be.

Prime Minister, the power of our endeavour is the true promise of the people of our country. Each of us as leaders must endeavour to put Canadian values into action as we leave this room.

I want to say a special thank you to the leaders of the national Aboriginal organizations because, indeed, for all of us, we should recognize the greatest risk at coming to this table was theirs.

It is sometimes easier to stand back and deal with the problems you have and say, "Let's not try something new. Let's not challenge the status quo. Let's stay mired in the past."

Each of the Aboriginal leaders who joined us looked to the future. Each of the Aboriginal leaders who have joined us and been part of this discussion in shaping the discussion and planning for their future said they were willing to take the risk on behalf of the people that they serve.

And I particularly want to recognize the exceptional leadership that has been shown by National Chief Phil Fontaine of the Assembly of First Nations.

It was the national chief who came to us and said, "Let us put aside the search for headlines and let us look for solutions. Let us recognize that solutions will come not in a year or two, but that we will have to commit ourselves for a decade. We will have to commit resources. We will have to commit creativity. We'll have to commit to getting results, but most importantly we will have to relentlessly pursue this plan." We must relentlessly pursue it if we are to be successful.

And I want to thank all of the leaders. The Métis National Council, the ITK, the AFN, Council of Aboriginal People and the Native Women's Association of Canada for sharing with us their goals and their dreams.

And Prime Minister, I want to recognize and acknowledge the work of Minister Scott. I have traveled across the country a couple of times. He's traveled across the country dozens of times in pursuit of this agenda and laying out this plan.

And finally, let me say thank you to you, Prime Minister, because it is equally a risk for you to say, "Let's get together with the premiers again." Not a big risk. But it's a reasonable risk.

I think that, Prime Minister, you opened a door for all of us and as you opened that door each premier walked through. As you opened that door, each Aboriginal leader came forward and said, "Let us guide you to a future that we can all embrace."

So, I want to say on behalf of all of us thank you for establishing this. Thank you for creating the opportunity for us to reach for a Canada that we all aspire to.

Someone once said, "Whatever you can do or dream you can do, begin it. Boldness has genius, power, and

magic in it."

I am hopeful that what we have done in the last two days will create some magic for First Nation, Inuit, and Métis people across this country. We will transform their lives and all Canadians will be proud of the efforts and the energy we put behind that.

Thank you very much Prime Minister.

Pilot project reduces wait times for hip and knee replacements *Pix Insert photo of Carol Sutton*

Richmond patients are not waiting as long for hip and knee replacements, thanks to a successful pilot project at the Richmond Hospital (RH).

"We've been able to provide patients with earlier access to service and improved outcomes, as a result of this project," says Orthopedic Surgeon **Dr. Ken Hughes**, co-lead for the Hip and Knee Reconstructive Project. "Our joint replacement surgical teams have gotten so good at these procedures that we've been able to lower the median wait time for hip and knee surgery in Richmond, from 19 to seven months."

"We received additional resources to perform more procedures," adds Project Co-lead **Cindy Roberts**. "Surgical teams can complete six cases a day, when they used to manage three. We were able to plan for 650 surgeries at RH in 2005, an increase of 136% over the procedures handled before the project was launched in fall 2004."

Before the project, wait times for hip and knee replacements in Richmond ranged from 8.9 to 20.6 months, although research indicates that patients who have surgery within six months have better outcomes. Since it began, the project has succeeded in decreasing:

- The number of people waiting for surgery by 16%.
- The number of patients waiting more than 24 weeks for surgery by 63%.
- Patients stay in hospital by 25%.

"I was in constant pain before my surgery, and could not move more than a block at a time," says patient **Carol Sutton**, who had a hip replacement in late 2004. "My ability to work and take care of my family and home was dramatically reduced. To my delight, the surgery went smoothly, and the healing process was quick. Everyone at Richmond Hospital was fabulous. And the result has been miraculous; I have my life back."

Pullout (like a pullout quote):

Pilot Project shares learning with other hospitals

The pilot project produced a practical toolkit for other hospitals in B.C. to use, with patient and surgeon outcome measures, a waitlist prioritization tool, and a clinical pathway to deliver the most efficient, cost effective program and reduce hospital stays.

End pullout

VCH, the Provincial Health Services Authority, the Ministry of Health and the Richmond Hospital Foundation all provided funding for the pilot project to the end of 2005. Based on its success, the new approach has now become part of regular operations.

"Ultimately, our goal is to ensure all patients receive surgery within six months of the decision to proceed with surgery," says Roberts.

For more information, please contact Cindy Roberts at 604-244-5121.

Native communities develop pilot programs to prevent fetal alcohol syndrome

Provided by: Canadian Press Written by: SHERYL UBELACKER Jan. 09, 2006

TORONTO (CP) - Four Canadian aboriginal communities, working in partnership with university researchers, have each developed culturally sensitive intervention programs aimed at preventing alcohol-related birth defects in children.

Fetal alcohol spectrum disorder (FASD), in which children are born with mild to severe physical and intellectual disabilities, occurs when women ingest alcohol during pregnancy. Binge drinking is considered a particularly high-risk behaviour that may lead to brain damage in the developing fetus.

The four native groups - two in Ontario and two in British Columbia - developed their programs based on what they believed would work best for women in their individual communities, said principal investigator Paul Masotti, an assistant professor of community health and epidemiology at Queen's University. Each group "did things drastically different," Masotti said from Kingston, Ont., noting that they used indigenous knowledge specific to their own people to design the programs.

Most importantly, the FASD-prevention programs were created by the community members themselves, he said. Researchers from five universities - Queen's, McMaster in Hamilton, Lakehead in Thunder Bay, Ont., Vancouver's UBC and Wisconsin in Madison - provided information on the steps needed to fashion an intervention program and various research methods, then stepped back.

"One of the most unique things that we built into the methodology is that we never once set foot in the community and conducted research," said Masotti.

The three-year, \$600,000 project was funded by the Canadian Institutes of Health Research in conjunction with the Institute of Aboriginal People's Health. Its two major goals, described in an article published this week in the open-access online journal PLoS Medicine, were to design community-specific FASD intervention programs and to increase research capabilities within aboriginal communities.

So instead of non-aboriginal social scientists parachuting into communities, conducting research and then leaving, the project was aimed at creating a truly equal partnership between university-and community-based researchers, Masotti said.

"Researchers historically did not consider the communities full partners and so consequently a lot of research happened that did not benefit the communities - it only benefited the researchers," he said.

"What we learned is that there is . . . indigenous knowledge or ways of acquiring knowledge . . . and the university folks have to be respectful of the communities and how they do things differently . . . We had to learn to listen and to learn."

Health Canada estimates that about one per cent of Canadians, or about 300,000 people, have some form of FASD. The prevalence is reported to be higher among native Canadians, but experts say the condition is so under-reported - children are often misdiagnosed with attention-deficit hyperactivity disorder (ADHD) - that the numbers are unreliable.

In mild cases of fetal alcohol spectrum disorder, brain damage may entail loss of some IQ, vision problems and higher than normal pain tolerance, says the Fetal Alcohol Disorders Society of Canada.

In severe cases, the child may suffer severe loss of intellectual potential, serious vision problems, facial deformities, heart defects, behavioural problems, poor judgment and sociopathic behaviour, the society says.

Children who are not properly diagnosed and given remedial treatment may struggle with lifelong behavioural problems that often result in an inability to stay in school, difficulty maintaining steady employment and trouble with the law.

Masotti said aboriginal researchers had to consider a number of questions when designing programs to prevent FASD, including: How would you approach a woman in the community? How would you ask her sensitive questions about alcohol use during pregnancy? What is the right location to conduct the intervention? What is the best way to communicate information about the harm that alcohol can do?

Although the four communities have pilot-tested their interventions, the results won't be published for about a year, he said.

The different programs will then be offered to help prevent FASD in other aboriginal communities across Canada, the United States and elsewhere in the world, with the idea that they can be tweaked to reflect individual populations.

Masotti said the programs are also intended as templates for other medical-social issues communities may struggle with, such as teen suicide and diabetes.

From Family and Children's Health at Medbroadcast.com

Please share the following announcement with colleagues within First Nation communities of practice, educators and learners, and those interested in preserving First Nations languages.

Language in First Nations Culture, March 13 - 18, 2006

The Aboriginal Language Revitalization Program <http://www.uvcs.uvic.ca/calr> , offered jointly by the University of Victoria and the En'owkin Centre, is offering a six-day immersion course in mid-March to explore the profound ways in which aboriginal languages are linked to aboriginal worldview and cultural practices, along with the cultural implications of language loss and recovery. This course is offered in partnership with the Saanich Native Heritage Centre and Cowichan Tribes, and will be located in Saanich, just outside Victoria, Vancouver Island, BC. Participants may take the course on a non-credit basis, or earn 1.5 units of academic credit toward the Certificate in Aboriginal Language Revitalization or toward other programs. Further information on this course is available at <http://www.uvcs.uvic.ca/calr/courses.aspx#186>

We also encourage you to explore the rest of the website and consider participation in the 2006 Summer Institutes that provide the core courses needed to work toward the Certificate in Aboriginal Language Revitalization -- please let us know if you have questions!

Best wishes,

Lisa Mort-Putland, Program Coordinator
Cultural Resource Management Programs
Division of Continuing Studies, University of Victoria
E-mail: lmort-putland@uvcs.uvic.ca
Tel: (250) 721-6119

For more information on upcoming courses please visit our web site www.uvcs.uvic.ca/crmp

VCH has a new Strategy for Palliative – Hospice – End-of-Life Care

Members of the public, as well as health care providers in this region, have called for more and better palliative - hospice - end-of-life care services. And VCH is listening. The Senior Executive Team recently approved a new region-wide palliative care strategy to address the needs of those facing life-threatening illnesses, as well as the needs of the significant people in their life.

End-of-life care refers to the many supports and services available to people with a life-threatening illness who are seeking options that focus on comfort care, pain and symptom management as the primary goal of care. “This includes the care of the whole person and their significant others, including psychosocial, spiritual and physical needs,” explains **Nellie Hariri**, Project Leader.

Pullout –

Did you know?

Studies from across Canada estimate that only 15% of people needing end-of-life care are actually accessing these services. Estimates in this province suggest that 65% of people who die from a life-threatening illness in any given year would benefit from quality end-of-life care but less than 25% have access, often due to palliative services not being available or fully explained and understood.

End of pullout

The recently approved Regional Palliative Care Strategy is a five-year plan to develop and implement a regional approach to palliative (end-of-life) care. The Strategy was developed in consultations with providers. Community engagement focus groups were also conducted in all VCH geographic communities, in four different languages and with our Aboriginal communities.

The goals of the plan include:

1. Quality hospice palliative care available regardless of setting (including home, residential care, acute care, hospice)
2. Increased and earlier access to services in the illness trajectory (one year prognosis compared with the current three to six months)
3. More people with non-cancer diagnoses also accessing the service
4. More people with an identifiable primary care provider (family doctor)
5. More people able to spend their last days in home and home-like settings
6. More emphasis on grief and bereavement supports
7. More supports and education for staff
8. More public and community education and discussion about death and dying
9. More supports to enable people to express their wishes about care

Over the next few months, the project team will prepare a business case and develop an implementation plan for a five-year phased in approach. “This is a huge milestone,” says Hariri, “to have SET approval and consensus across VCH on our key principles, philosophy and an integrated model of care is a first step to improving access to palliative –hospice- end-of-life care.”

Shaded box:

Currently, VCH offers the following end-of-life care across VCH:

- In 2004/05, VCH added 29 new hospice beds across the whole region, bringing the total to 48. By 2010/11, the Regional Palliative Strategy calls for a total of 87 beds across VCH.
- Specialized Palliative Care Teams in each HSDA are experiencing increasing demand for their expertise. They will expand in capacity as the Strategy is implemented. These teams serve clients and families regardless of setting. They also provide palliative consultation to colleagues upon request.

- Each Health Service Delivery Area currently has specialized palliative care acute care beds (PCU) that provides highly complex pain and symptom management.
- Specific projects are underway in each HSDA to further develop services based on priority needs identified by their communities.

Side bar:

Definition of:

Hospice

Palliative

End-of-Life Care

These terms are often used interchangeably and refer to the continuum of clinical and support services appropriate for individuals with a life threatening illness and their families, regardless of diagnosis and setting of care. These services aim to relieve suffering and improve the quality of living and dying. They help patients and families address physical, psychological, social, spiritual and practical issues, as well as their associated expectations, needs, hopes and fears. It also helps them manage end of life decisions and the dying process, including coping with loss and grief during the illness and bereavement. These services include both a palliative approach, specialist palliative care, and terminal care provided to individuals facing a life-threatening illness and their family.

End side bar

For more information on these services, staff, clients, families, and community partners can contact the palliative services in each HSDA directly. If you wish to know more about the Regional Hospice Palliative End-of-Life Care Strategy, please contact Nellie Hariri at 604-714-3779.

Study bolsters evidence that you can't be fat and healthy at the same time

Provided by: Canadian Press Written by: LINDSEY TANNER Jan. 11, 2006

CHICAGO (AP) - Middle-age people who are overweight but have normal blood pressure and cholesterol levels are kidding themselves if they think their health is just fine.

Northwestern University researchers tracked 17,643 patients for three decades and found that being overweight in mid-life substantially increased the risk of dying of heart disease later in life - even in people who began the study with healthy blood pressure and cholesterol levels.

High blood pressure and cholesterol are strong risk factors for heart disease. Both are common in people who are too fat, and often are thought to explain why overweight people are more prone to heart disease.

But there is a growing body of science suggesting that excess weight alone is an independent risk factor for heart attacks, strokes and diabetes.

The new study fits with that evolving school of thought and contrasts with a controversial government study published last year that suggested excess weight might not be as deadly as previously thought.

"The take-home message would be pay more attention to your weight even if you don't have an unhealthy risk factor profile yet," said lead author Lijing Yan, a researcher at Northwestern and Peking University.

The study appears in Wednesday's Journal of the American Medical Association.

Participants were Chicago-area men and women in their mid-40s on average who had no heart disease or diabetes when the study began. They were followed for an average of 32 years. The researchers tracked deaths from cardiovascular disease and diabetes, and hospitalizations for those conditions, starting at age 65.

A total of 1,594 heart disease deaths occurred, 31 of them in people who started the study with normal blood pressure and cholesterol.

Among participants with normal blood pressure and cholesterol at the start, those who were obese - or grossly overweight - were 43 per cent more likely than normal-weight participants to die of heart disease later on. They were also four times as likely to be hospitalized for heart disease.

Participants who were modestly overweight but had normal blood pressure and cholesterol still ran a higher risk than the normal-weight people.

A total of 1,187 participants - 494 of them overweight or obese - had normal blood pressure (120 over 80 or lower) and cholesterol levels (under 200) at the outset. Standard body-mass index categories were used to define weight - BMIs of 25 to 29 were considered overweight and 30 and above was obese.

Yan said it is possible that some overweight participants developed high blood pressure and cholesterol problems during the study, which could have contributed to their deaths. But she said researchers increasingly believe that being too fat causes other cardiovascular problems, too.

Fat tissue "is not like an inert storage depot - it's a very dynamic organ that is actually producing hormones and chemical messengers," said Dr. JoAnn Manson, chief of preventive medicine at Harvard's Brigham and Women's Hospital. These substances can damage blood vessels, increase the risk of blood clots and cause insulin resistance that makes people prone to diabetes - all without elevating blood pressure or cholesterol, said Manson, who was not involved in the Northwestern study.

Still, there is a common misconception that excess weight is nothing to worry about until high blood pressure and poor cholesterol develop, and those can then be treated with medications, Manson said. "Patients say that all the time, and many doctors actually will say that to patients" too, she said.

The study "will help define obesity as a disease" in itself, said Dr. Samuel Klein, an obesity expert at Washington University in St. Louis.

Dr. David Katz, an obesity researcher and director of Yale University's Prevention Research Center, said the findings help prove obesity is a real public health crisis. "People who say obesity has been hyped are wrong," Katz said.

GREAT TRUTHS ABOUT GROWING OLD

- 1) Growing old is mandatory; growing up is optional.**
- 2) Forget the health food. I need all the preservatives I can get.**
- 3) When you fall down, you wonder what else you can do while you're down there.**
- 4) You're getting old when you get the same sensation from a rocking chair that you once got from a roller coaster.**
- 5) It's frustrating when you know all the answers but nobody bothers to ask you the questions.**
- 6) Time may be a great healer, but it's a lousy beautician.**
- 7) Wisdom comes with age, but sometimes age comes alone.**

Grassroots Group Calls for Implementation of Indian Residential School Deal Before Too Many More Elderly and Sick Survivors Die

(Vancouver–January 20, 2006) A newly-formed grassroots survivors group in British Columbia is calling on the next Government to honour the Indian Residential School Agreement-in-Principle that was signed on November 20, 2005. The *Survivors of the Canadian Indian Residential School Holocaust (SCIRSH)* are concerned and upset that the settlement package may be in jeopardy.

“Polls suggest that the Conservative Party of Canada will form the next government,” stated Ron Hamilton, SCIRSH Spokesperson. “We call on Stephen Harper to commit to honouring the deal and implementing it quickly should he be elected Prime Minister,” he added. While several party leaders have endorsed the deal, Mr. Harper’s position has been unclear. He has indicated that, if elected, the Conservatives would make “slight adjustments” to the deal. Given that it is a court mediated settlement, the Survivors fear that alterations to the deal will cause it to collapse.

“We are finally close to taking the first steps towards closure on this issue after carrying the pain and trauma of our residential school experience for so many years. We want Mr. Harper to be forthcoming and tell us clearly what changes he plans to make,” said Spokesperson Charlie Thompson. “We want his assurance that the deal will go through if his party is elected.”

Survivors have waited far too long—up to seventy years for some—for official recognition of the abuses they suffered in the Indian residential school system. They are frustrated and angry at, once again, feeling they are at the mercy of forces beyond their control. While SCIRSH feels that the deal falls short in providing adequate compensation and resources for ongoing healing, they recognize that, for many, this deal represents the only acknowledgment they will ever receive.

“We cannot afford to wait longer. Our average age is 60. Most of our elders don’t understand the politics of the process. They are tired and all they want is for this to be settled,” Spokesperson Ron Hamilton said.

“It is estimated that thirty of our schoolmates take the pain and suffering inflicted on them in the schools to their graves every week. Those who have passed on will never know what it feels like to have even a small measure of justice. They will never feel the relief that comes with knowing they were not to blame for what happened to them,” added Spokesperson Charlie Thompson. “We want as many survivors as possible to be able to benefit from this deal. The longer we wait, the more will die.” In 1990, when former students of the Indian Residential Schools began talking about abuses in the schools, there were 105,000 of them. That number has dropped to about 70,000 today.

Many other groups who have suffered as a result of government policy have already received recognition and redress. Moreover, the Government of Canada recently announced that it would apologize for the Chinese Head Tax. Why is it that we—the indigenous peoples of this land—have to wait so long for a formal apology and restitution?

SCIRSH also calls on the next government to immediately go ahead with the advance payment of \$8,000 that is provided for in the deal for survivors 65 and older. The payment has been expected for some time. Many of the survivors—especially the elderly and sick—have often had their expectations raised as a result of all the public attention. They are anxiously awaiting the advance payment. They are ready to begin the slow process of bringing closure to their experience. Now, they are beginning to fear that they will never achieve that. Many feel like wrongfully condemned inmates on death row.

In November 2005, the federal government announced a compensation settlement for harms suffered in the Indian Residential School system. The settlement included an advance payment of \$8,000 in early 2006 for those 65 and older. Also included in the settlement was a Truth and Reconciliation process, a Commemoration process and funding for the Aboriginal Healing Foundation.

The Indian Residential School system operated from the mid-19th century to 1996. In over 100 schools across Canada, Aboriginal school-aged children were forcibly removed from their homes and placed in the schools. Many were abused physically, sexually, mentally, emotionally and spiritually. Many received sub-standard education and were forced to do manual labour in maintenance of the schools. Many died in the schools and afterward as a result of the pain suffered there.

The Survivors of the Canadian Indian Residential School Holocaust are grassroots survivors from across British Columbia. We came together when it was announced that a settlement of the Indian Residential School issue was being worked on. We came together because we are tired of being on the sidelines of decisions that are being made on our behalf. We want to make sure that we participate fully in any process affecting us, our families and communities. We work collaboratively with the Indian Residential School Survivors Society to give them feedback on issues of concern to us. The group meets bi-weekly via a provincial teleconference. The group includes survivors from Nanaimo, Duncan, Vancouver, Squamish, Kelowna, Penticton, Prince George, Terrace, and Kitimaat.

For more information contact:

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Nanoose, BC
(250) 390-2257

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Port Alberni, BC
(250) 724-9667

WARNING...New Credit Card Scam - Note, the callers do not ask for your card number; they already have it.

This information is worth reading. By understanding how the VISA & MasterCard Telephone Credit Card Scam works, you'll be better prepared to protect yourself. My husband was called on Wednesday from "VISA", and I was called on Thursday from "MasterCard".

The scam works like this: The person calling says, "This is (name), and I'm calling from the Security and Fraud Department at VISA. My Badge Number is 12460. Your card has been flagged for an unusual purchase pattern, and I'm calling to verify. This would be on your VISA card, which was issued by (name of bank). Did you purchase an Anti-Telemarketing Device for \$497.99 from a Marketing company based in Arizona?"

When you say "No", the caller continues with, "Then we will be issuing a credit to your account. This is a company we have been watching and the charges range from \$297 to \$497, just under the \$500 purchase pattern that flags most cards. Before your next statement, the credit will be sent to (gives you your address). Is that correct?" You say "yes". The caller continues, "I will be starting a Fraud investigation."

If you have any questions, you should call nbsp; the 1-800 number listed on the back of your card (1-800-VISA) and ask for Security. You will need to refer to this Control Number. The caller then gives you a 6-digit number. "Do you need me to read it again?"

Here's the IMPORTANT part on how the scam works. The caller then says, "I need to verify you are in possession of your card".

He'll ask you to "turn your card over and look for some numbers". There are 7 numbers; the first 4 are part of your card number, the next 3 are the security numbers that verify you are the possessor of the card. These are the numbers you sometimes use to make Internet purchases to prove you have the card. The caller will ask you to read the 3 numbers to him. After you tell the caller the 3 numbers, he'll say, "That is correct, I just needed to verify that the card has not been lost or stolen, and that you still have your card. Do you have any other questions?" After you say No, the caller then thanks you and states, "Don't Hesitate to call back if you need to", and hangs up.

You actually say very little, and they never ask for or tell you the Card number. But after we were called on Wednesday, we called back within 20 minutes to ask a question. Are we glad we did!

The REAL VISA Security Department told us it was a Scam and in the last 15 minutes a new purchase of \$497.99 was charged to our card. Long story made short - we made a real fraud report and closed the VISA account. VISA is reissuing us a new number. What the scammers want is the 3-digit PIN number on the back of the card. Don't give it to them. Instead tell them you'll call VISA or MasterCard directly for verification of their conversation.

The real VISA told us that they will never ask for anything on the card, as they already know the information since they issued the card! If you give the scammers your 3 Digit PIN Number, you think you're receiving a credit. However, by the time you get your statement you'll see charges for purchases you didn't make, and by then it's almost too late and/or more difficult to actually file a fraud report.

What makes this more remarkable is that on Thursday, I got a call from a "Jason Richardson of MasterCard" with a word-for-word repeat of the VISA scam. This time I didn't let him finish. I hung up! We filed a police report, as instructed by VISA. The police said they are taking several of these reports daily!

They also urged us to tell everybody we know that this scam is happening. Please pass this on to all your family and friends. By informing each other, we protect each other.

Unfortunately, finding an effective skin care regimen for acne-prone skin can be quite a frustrating experience. But acne can be controlled, and it is important that you understand what type of acne you have and seek treatment as soon as possible to avoid scarring. The best way to treat your acne is to be informed, aware, and positive. **Find the right solution for your skin.** What works for your best friend may actually make your skin much worse. Only attempt to self-treat your acne if it is very mild. Your pharmacist can help you choose the right product for you.

Here are a few basic steps to help you along the path to clearer skin:

Step 1: Clean. The first step is to cleanse the skin. Wet your face, then massage the cleanser onto skin in gentle circular motions for 15 seconds to 5 minutes, then rinse off thoroughly. Never wipe or rub your face with the towel; blot or pat it dry. Keep these extra tips in mind when you're cleansing your skin:

- Use a mild cleanser or medicated cleansers with either salicylic acid or benzoyl peroxide in the morning and before bedtime.
- Do not wash excessively or scrub too hard. This can strip the skin of its natural oils and may irritate already-present acne.
- Avoid cream-based cleansers if you have oily skin. They may make your skin even oilier.
- Some cleansers can also dry your skin, especially if you use them too much. You may have to try a few products before you find one that works well.

Step 2: Moisturize. After cleansing the skin, use a light, oil-free moisturizer. If your skin is very oily, you might want to skip this step. If using a moisturizer, ensure that the label reads "non-acnegenic" or "non-comedogenic."

Step 3: Treat. Most of the over-the-counter topical (skin-applied) treatments for acne contain benzoyl peroxide, salicylic acid, zinc, or sulfur. Treatments are available in gels, solutions, creams, lotions, or pads. Before you use a new product on your face, always test the product on a small patch of skin on your arm or behind the ear to see if you are sensitive to the product. If the product causes too much irritation (e.g., redness, stinging, or peeling), look for a lower-strength product or use it less frequently.

Apply topical solutions all over the acne-prone areas, not just on the visible blemish, to prevent formation of additional acne. If your acne is not improving after 6 to 8 weeks of use, contact your doctor or dermatologist for a more effective treatment.

Quick tips:

- Remember to use clean towels and wash your pillowcase and sheets regularly.
- If you must use hair products, keep your hair out of your face, as the product could irritate skin and cause breakouts.
- When choosing cosmetics or any other type of face product, test behind the ear for at least one week to see if it is tolerated
- Use medicated, oil-free cosmetics. Concealers are available in many shades that will cover up the pimples and treat them at the same time.
- Do not wash your face excessively.
- Make sure to cleanse your face after rigorous exercise.
- Use scrubs cautiously, as they may irritate skin.
- Do not manipulate pimples with your fingers (squeezing or picking) or touch your face excessively, as they heal better and faster without touching.

Smoking by mothers may increase risk of colic in babies: report from medbroadcast.com

Provided by: Canadian Press

Written by: LINDSEY TANNER

CHICAGO (AP) - Mothers who smoke during or after pregnancy increase their babies' risk of developing colic, those vexing, inconsolable crying spells that affect up to 20 per cent of babies in their first few months of life, researchers say.

The culprit, based on studies in adults, is likely nicotine, which increases blood levels of a gut protein involved in digestion, said Brown University epidemiologist Edmond Shenassa. That may result in painful cramping that makes babies cry, he said. Shenassa and Harvard University researcher Mary-Jean Brown reviewed several studies, including six that involved more than 12,000 babies.

The data suggest that compared with non-smokers, mothers who smoke during pregnancy face about double the risk of having infants with colic, Shenassa said.

Second-hand smoke - from parents and others who light up around the baby - also appears to increase the risk for colic, but Shenassa said more research is needed to sort out how much those factors increases the risk.

Smoking by mothers already has been linked with an increased risk for low birth weight, sudden infant death syndrome and respiratory problems in infants.

"If, as we suspect, exposure to cigarette smoke increases the risk of colic, then this would provide additional incentives to parents to abstain from smoking," the researchers said.

The report appears in the October edition of Pediatrics, published Monday.

Classic colic - crying spells occurring at least three hours daily, at least three times weekly, for at least three weeks - tends to peak at two months and gradually disappear by about three or four months of age.

Other research has suggested that some cases may be caused by an inability to properly digest milk proteins or fruit juice sugars, though some scientists believe colic is normal behaviour for some babies that may be exacerbated but not caused by outside influences.

Shenassa said evidence of nicotine increasing levels of the protein motilin, which is involved in controlling intestinal activity, comes from studies of adult smokers.

Dr. Ronald Barr, a University of British Columbia pediatrics professor who was not involved in the research, called the paper "a very nice review of the literature" and said it provides sound reasons "to suggest that smoking might be contributory."

But Barr noted that some of the reviewed data showed that a sizable number of babies born to non-smokers had colic, and he argued that smoking would not cause colic in infants who aren't already predisposed.

TO THE WONDERFUL WOMEN IN MY CIRCLE!! (forwarded in for the newsletter)

When I was little, I use to believe in the concept of one best friend, and then I started to become a woman. And then I found out that if you allow your heart to open up, God will show you the best in many friends.

One friend's best is needed when you're going through things with your man. Another friend's best is needed when you're going through things with your momma. Another when you want to shop, share, heal, hurt, joke, or just be. One friend will say let's pray together, another let's cry together, another let's fight together, another let's walk away together.

One friend will meet your spiritual need, another your love for cowboys, another will be with you in your season of confusion, another will be your clarifier, another the wind beneath your wings. But what ever their assignment in your life, on whatever the occasion, on whatever the day, or where ever you need them to meet you with their gym shoes on and hair pulled back or to hold you back from making a complete fool of yourself...those are your best friends.

It may all be wrapped up in one woman, but for many it's wrapped up in several...

One from 7th grade, One from high school, several from the college years, a couple from old jobs, several from church, it could be an auntie or a grandmother, on some days your mother, on others your sisters, and on some days it's the one that you needed just for that day or week that you needed someone with a fresh perspective, or the one who didn't know all your baggage, or the one who would just listen without judging...those are good girlfriends/best friends.

Men are wonderful, husbands are excellent, and boyfriends are awesome, male friends are priceless...but if you've ever had a real good girlfriend, then you know there's nothing like her!

I thank God for girlfriends. Those who honor intimacy, those who hold trust, and those who just got your back when you feel like life is just too heavy!

I thank God for you. The special bond we share, that's unique to us. The words we've shared. The prayers we've sent up. The laughs, the tears, the phone calls, the emails, the shopping, the movies, the lunches, the dinners, the late night talks, afternoon talks, the weekend talks, all the talking, talking, talking and the listening, listening, listening....

So whether you've been there 10 minutes or 10 years, know that I do love you and am grateful for all the times you've ever been there!!!

Pass this on to the women who make a difference in your life!

Quotes

“Not failure, but low aim is the crime.”

“Bless a thing and it will bless you. Curse it and it will curse you...If you bless a situation, it has no power to hurt you, and even if it is troublesome for a time, it will gradually fade out, if you sincerely bless it.”

Emmet Fox

“Grace strikes us when we are in great pain and restlessness...Sometimes at that moment a wave of light breaks into our darkness, and it is as though a voice were saying: you are accepted.” Paul Johannes Tillich

“Taking joy in life is a woman’s best cosmetic.

Rosalind Russell

“An interior is the natural projection of the soul.”

Coco Chanel

Pomegranate juice offers sweet health benefits for heart disease patients

Oct. 17, 2005

Provided by: MediResource

Written by: ADAM MICHAEL SEGAL

TORONTO (MRI) - The tasty seeds of the pomegranate appear to offer some sweet health benefits for coronary heart disease patients, according to new research.

A study of a small group of patients with coronary heart disease found that drinking about one cup (240 mL) of pomegranate juice daily helped reduce stress-induced myocardial ischemia, poor blood flow to the heart muscle brought on by stress or exercise.

"The results of this study demonstrate, for the first time, that daily consumption of pomegranate juice for three months may decrease myocardial ischemia and improve myocardial perfusion in patients who have (coronary heart disease)," writes the study's lead author, Michael Sumner, of the Preventive Medicine Research Institute.

"Although the sample in this study was relatively small, the strength of the design and the clinically significant improvements in myocardial perfusion observed in the experimental group ... suggest that daily consumption of pomegranate juice may have important clinical benefits in this population."

The researchers examined 45 coronary heart disease patients who had poor blood flow to the heart muscle.

The patients were divided into two groups, with the experimental group drinking a daily cup of pomegranate juice for three months and the control group drinking a placebo, a similar-looking and similar-flavoured beverage that did not contain pomegranate juice.

Electrocardiographic images were captured to assess the effect of the juice on myocardial ischemia.

Results showed that study participants who drank the pomegranate juice experienced a 17% improvement in blood flow to the heart muscle, whereas those given a placebo beverage had an average worsening of 18%.

As for the underlying reasons why the juice had positive effects, the researchers point to its high levels of polyphenols, a group of vegetable chemical substances that have been shown to act as antioxidants.

"Our findings are consistent with results reported by others who have demonstrated the beneficial effects of beverages high in polyphenols," note the researchers.

The researchers add that further studies of a similar nature should be conducted with larger groups and for a longer period of time.

From Senior's Health @ medbroadcast.com

Little Miracles: *“A miracle is not the suspension of natural law, but the operation of a higher law...”*

A little girl went to her bedroom and pulled a glass jelly jar from its hiding place in the closet. She poured the change out on the floor and counted it carefully. Three times, even. The total had to be exactly perfect. No chance here for mistakes. Carefully placing the coins back in the jar and twisting on the cap, she slipped out the back door and made her way 6 blocks to Rexall's Drug Store with the big red Indian Chief sign above the door.

She waited patiently for the pharmacist to give her some attention but he was too busy at this moment. Tess twisted her feet to make a scuffing noise. Nothing. She cleared her throat with the most disgusting sound she could muster. No good. Finally she took a quarter from her jar and banged it on the glass counter. That did it!

"And what do you want?" the pharmacist asked in an annoyed tone of voice. "I'm talking to my brother from Chicago whom I haven't seen in ages," he said without waiting for a reply to his question.

"Well, I want to talk to you about my brother," Tess answered back in the same annoyed tone. "He's really, really sick.... and I want to buy a miracle." "I beg your pardon?" said the pharmacist.

"His name is Andrew and he has something bad growing inside his head and my Daddy says only a miracle can save him now. So how much does a miracle cost?"

"We don't sell miracles here, little girl. I'm sorry but I can't help you," he said, softening a little.

"Listen, I have the money to pay for it. If it isn't enough, I will get the rest. Just tell me how much."

The pharmacist's brother was a well-dressed man. He stooped down and asked the little girl, "What kind of a miracle does your brother need?"

"I don't know," Tess replied with her eyes welling up. "I just know he's really sick and Mommy says he needs an operation. But my Daddy can't pay for it, so I want to use my money."

"How much do you have?" asked the man from Chicago.

"One dollar and eleven cents," Tess answered barely audibly. "And it's all the money I have, but I can get some more if I need to."

"Well, what a coincidence," smiled the man. "A dollar and eleven cents---the exact price of a miracle for little brothers."

"He took her money in one hand and with the other hand he grasped her mitten and said "Take me to where you live. I want to see your brother and meet your parents. Let's see if I have the miracle you need."

That well dressed man was Dr. Carlton Armstrong, a surgeon, specializing in neuro-surgery. The operation was completed free of charge and it wasn't long until Andrew was home again and doing well. Mom and Dad were happily talking about the chain of events that had led them to this place.

"That surgery," her Mom whispered. "was a real miracle. I wonder how much it would have cost?"

Tess smiled. She knew exactly how much a miracle cost...one dollar and eleven cents plus the faith of a little child.

Controlling blood pressure can add years to your life

Provided by: MediResource Written by: ALYSSA SCHWARTZ

TORONTO (MRI) - Five years. That's how much time keeping your blood pressure under control can tack onto your life, according to a new study.

Using data from the Framingham Heart Study, researchers at the University of Rotterdam's Department of Public Health looked at the effect of high blood pressure on the life expectancy of some 3,128 men and women who had either normal or high blood pressure at the age of 50.

"Limited information exists about the consequences of hypertension during adulthood on residual life expectancy with cardiovascular disease," the researchers wrote in *Hypertension*, a journal of the American Heart Association. "We aimed to analyze the life course of people with high blood pressure levels at age 50 in terms of total life expectancy and life expectancy with and without cardiovascular disease compared with normotensives (people with normal blood pressure)."

Data spanning 28 years, on average, was collected from participants who had turned 50 during the study.

After accounting for differences in age, smoking, BMI and other factors, the researchers found that subjects who had normal blood pressure lived an average of 5 years longer than those who had high blood pressure, and lived more years free from heart disease. Compared to men with high blood pressure, men who had normal blood pressure at the age of 50 lived about 7 years longer without heart disease. When the men with normal blood pressure did develop heart disease, they tended to have two more disease-free years than the men who had high blood pressure.

"Increased blood pressure in adulthood is associated with large reductions in life expectancy and more years lived with cardiovascular disease," the researchers concluded. "This effect is larger than estimated previously and affects both sexes similarly."

Your target blood pressure level depends on your other existing risk factors for heart disease and stroke. According to the Heart and Stroke Foundation of Canada, most adults should aim for blood pressure levels below 140/90 mm Hg. For people with diabetes or kidney disease, Heart and Stroke recommends reducing your blood pressure to below 130/80 mm Hg. Based on your own risk level, your doctor may recommend a different target.

Generally, the first line of treatment for reducing blood pressure is lifestyle modification such as changing your eating habits, reducing the salt in your diet, exercising and quitting smoking. But if these don't achieve the desired results, your doctor may prescribe medication.

Men's Health @ medbroadcast.com

GREAT TRUTHS THAT LITTLE CHILDREN HAVE LEARNED:

- 1) **No matter how hard you try, you can't baptize cats.**
- 2) **When your Mum is mad at your Dad, don't let her brush your hair.**
- 3) **If your sister hits you, don't hit her back. They always catch the second person.**
- 4) **Never ask your 3-year old brother to hold a tomato.**
- 5) **You can't trust dogs to watch your food.**
- 6) **Don't sneeze when someone is cutting your hair.**
- 7) **You can't hide a piece of broccoli in a glass of milk.**
- 8) **Don't wear polka-dot underwear under white shorts.**
- 9) **The best place to be when you're sad is Grandpa's lap.**

Smoking puffs up breast cancer risk

Oct. 17, 2005

Provided by: MediResource

Written by: ALYSSA SCHWARTZ

TORONTO (MRI) - Researchers have found yet another toll years of smoking can take on your health: an increased risk of developing breast cancer.

Researchers found that older women who have smoked for the equivalent of 11 or more "pack years" - the lifetime equivalent of 20 cigarettes per day for 11 years - have as much as a 40% increased risk of developing breast cancer.

"Breast cancer may be an additional risk to add to the long list of adverse outcomes related to smoking," wrote Dr. Christopher Li and colleagues in the journal *Cancer Causes and Control*.

In one of the first studies to look at the long-term effects of smoking on older women, Li and his team compared data from 975 women between the ages of 65 and 79 who had been diagnosed with breast cancer and 1007 women of the same age range who had no history of breast cancer. All participants were interviewed about their smoking habits and history and were questioned about a variety of factors known to play a role in breast cancer development, including postmenopausal use of hormone replacement therapy; menstrual, contraceptive and reproductive history; family history; and alcohol use.

Overall, women who had a history of smoking - whether in the past or at the time of breast cancer diagnosis - had a 30% higher risk of developing breast cancer than women who had never smoked. After a closer analysis of the numbers, the researchers found the following:

- Women who were current smokers had a 40% higher risk of breast cancer, while the risk for former smokers was 20% higher than that of women who never smoked.
- Women who smoked for 40 years or longer had a 40% higher breast cancer risk than women who never smoked.
- Women who smoked for 11 or more "pack years" had a 30-40% greater risk.
- Women who started smoking before giving birth had a 30% higher risk of developing breast cancer, while women who started smoking after giving birth had a 10% greater risk.
- In former smokers, breast cancer risk decreased as the number of years since quitting increased.

Though the effect was not found to be statistically significant, the researchers also found that smoking and using hormone replacement therapy may interact to raise a women's breast cancer risk. This relationship only seemed to exist for women who used combined estrogen-progesterone therapy, not estrogen-only.

"To our knowledge, such an interaction has not been previously reported and thus requires confirmation," the researchers note.

The researchers note that previous investigations into the relationship between smoking and breast cancer have yielded conflicting results, but say that could be the result of different study designs as well as a variation in the age groups involved.

Women's Health at Medbroadcast.com

Calcium, vitamin D may prevent PMS

Provided by: MediResource

Written by: ALYSSA SCHWARTZ

TORONTO (MRI) - Milk, cheese and other dairy products are good for women's bones, but would you believe that they could also ward off the mood swings and irritability of PMS? A new study says they may.

While previous studies have shown that calcium could help women significantly reduce PMS symptoms, the latest research, published in the journal Archives of Internal Medicine, shows that consuming enough calcium and vitamin D could actually lower your risk of developing PMS in the first place.

PMS (premenstrual syndrome) refers to the mood swings, fluid retention, breast tenderness, fatigue and other symptoms that some women suffer in the days before their period begins. It's estimated that as many as 90% of women experience PMS to some degree, with 30% to 40% reporting symptoms so severe they interfere with daily life in some way.

Researchers at the University of Massachusetts set out to determine the effect of calcium and vitamin D consumption on pre-menopausal women by comparing women who had developed PMS with those who hadn't. Participants were between 27 and 44 years old at the start of the study and hadn't reported any symptoms of PMS. But over the next 10 years, 1,057 women went on to develop PMS, while 1968 did not.

After adjusting for age, smoking, and other risk factors, the researchers found that women who had the highest vitamin D intake (an average of 706 IU per day), had a 41% lower chance of developing PMS than the women who had the lowest intake. Women who consumed the equivalent of about 4 servings of skim or low-fat milk (providing approximately 1200 mg of calcium and 400 IU of vitamin D) per day also had a 30% lower chance of developing PMS compared to women who got the least calcium.

Recommended daily intake of vitamin D is 400 IU for women under the age of 50 and 800 IU for women over 50 years of age., Calcium intake also varies by age. For example, according to Health Canada, women between the ages of 19 and 50 should get 1,000 mg a day, while 1,200 mg are recommended for older women. Aside from dairy, foods that can help reach those recommendations include canned salmon with bones, calcium-fortified orange juice and broccoli.

The study didn't say whether calcium from supplements or from women's diets had a greater impact, however the authors did suggest that "given that calcium and vitamin D may also reduce the risk of osteoporosis and some cancers, clinicians may consider recommending these nutrients even for younger women."

But they emphasize that the study doesn't show that calcium and vitamin D prevent PMS - only that there is a link.

Women may have some success reducing the symptoms of PMS, however, by incorporating exercise into their daily routines, minimizing stress and limiting alcohol and caffeine. For women with severe symptoms, hormonal birth control or antidepressants may also be effective.

GREAT TRUTHS THAT ADULTS HAVE LEARNED:

- 1) Raising teenagers is like nailing jelly to a tree.**
- 2) Wrinkles don't hurt.**
- 3) Families are like fudge...mostly sweet, with a few nuts.**
- 4) Today's mighty oak is just yesterday's nut that held its ground.**
- 5) Laughing is good exercise. It's like jogging on the inside.**
- 6) Middle age is when you choose your cereal for the fibre, not the toy.**

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Anyone interested in advertising their products please contact the Elders Voice.

PROVERBS:

If you would be wealthy, think of saving as well as getting. Ben Franklin
If you would be pope, you must think of nothing else. Spanish
Ignorance is bliss. American
Let every fox take care of his own tale. Italian
Let no man deceive you with vain words. Biblical
Listen to all, plucking a feather from every goose, but follow no one abso-
lutely. Chinese

BIBLE QUOTES:

"I have learned, in whatever I have, therewith to be content. I know both how to be abased, and how to abound, how to be full and how to be hungry, how to have plenty and to suffer need. I can do all things through Christ who strengthens me." Philippians 4:11-13
"The Lord redeems the soul of his servants, and none of those who trust in him shall be desolate." Psalms 14:22
"He that refuses instruction despises his own soul, but he who hears reproof gets understanding." Proverbs 15:32
"Do not withhold payment from them to who it is due." Proverbs 3:27-28
"There the wicked cease from troubling; and there the weary be at rest"

Mail, fax, email, or call in your Special Wishes/Community Events !!

Happy! Happy! Birthday To All Elders Born In February!!

24 Hours a day - 7 days a week - **National Crisis Line** 1-866-925-4419
The Indian Residential School Survivors Society provides free, immediate, confidential, non-judgmental, support for residential school survivors across Canada

Quotations: "Old age ain't no place for sissies." Bette Davis
"Laugh and the world laughs with you. Cry and you cry with your girlfriends." Laurie Kennedy
"The phrase "working mother" is redundant." Jane Sellman
"Whatever women must do they must do twice as well as men to be thought half as good. Luckily, this is not difficult." Charlotte Whitton
"In politics if you want anything said ask a man - f you want anything done, ask a woman. " Thatcher
"When woman are upset the eat or go shopping, men invade another country. Elayne Boosler

ANNUAL BC ELDERS GATHERING INFORMATION CORNER

30th ANNUAL BC ELDER'S GATHERING

Hosts: Nuu-Chah-Nulth Tribal Council and Tseshah First Nation

Dates: July 18, 19, 20, 2006 **Place:** Alberni Valley Multiplex

Address: 3737 Roger Street, Port Alberni, B.C.

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