

# News and Views

Serving patients and families affected by GBS, CIDP, MMN and variants



## Rare is Strong!

Donna Hartlen, Executive Director

As you are well aware, we are rare! The first half of 2024 has been a whirlwind of community efforts to build critical awareness in our local communities and with medical professionals. I would like to sincerely thank each of you who submitted provincial and municipal proclamations, participated in and shared the 'Light it Up for GBS and CIDP' campaign, engaged in MMN Awareness month, participated in patient journey interviews that raise awareness and help connect the dots for other patients, tended medical association conference booths to represent the patient voice, and each of you who chaired, participated in, or donated to a spring Walk and Roll. This massive effort by our community members is extraordinary. Our vision for a better future is made possible by the gift of your time and donations, and we sincerely thank you for your generosity. Make sure you stay connected; we have a lot more raising awareness activities up our sleeves to finish out 2024, and educational programming you won't want to miss! Warmly,

*Donna Hartlen*

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## Walter Keast Award 2023

Congratulations Miranda and  
Ameliya Pellett!

Miranda and Ameliya are our first mother-daughter team. The Walter Keast Award is given to an individual/s for their exemplary service to the GBS, CIDP, MMN, and variant community.

The Foundation and the Keast Family are very proud of your efforts to strengthen our community. Thank you for your extraordinary efforts!

# Walter Keast Award 2023

## MIRANDA & AMELIYA PELLETT

Our first mother-daughter liaison team. Miranda and Ameliya are passionate about increasing GBS awareness. They also raised \$1,145.00 dollars to support critical programs.

Miranda & Ameliya have  
volunteered their time in 2023 to:

- Rare Disease Day video
- Montreal Walk and Roll
- New Patient Video
- Journey presentation for the 2023 International Symposium
- Patient communication
- Raising awareness on Facebook



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## ADVOCACY: SECURING THE CANADIAN SUPPLY OF IMMUNOGLOBULIN FOR OUR PATIENTS

Dear Patients, Caregivers, Liaisons, Volunteers, and Friends,

On behalf of the Board of Directors of the GBS/CIDP Foundation of Canada, I wanted to share with you a brief note on the activity of the Board and why it matters to our patient community. As Board members, our responsibility is to ensure that the Foundation is properly positioned to fulfil the four prongs of our mission: support, advocacy, research, and education. We can all be proud of the fact that the Foundation has grown from nothing just two short decades ago to this positive force that each day makes a difference in the lives of patients. We couldn't have done it without your support.

When we make decisions as a Board, we make them in the best interests of patients with GBS, CIDP, MMN, or variants. To do this, we are guided by the advice from the respected experts on our Medical Advisory Board.

As an example, about three years ago, based on that advice the Board formally adopted the position that we support the compensation of plasma donors in Canada. (Note that we also reaffirmed that whole blood donors should never be paid.) Given that it can take up to 1,000 plasma donors to produce enough immunoglobulin for one of our patients, experts have said that the option to incentivize at least some donors needs to be available. Our Medical Advisory Board also warned that relying on more than half of our immunoglobulin (IG) imported from foreign sources is very risky. The COVID-19 pandemic only underscored how quickly a supply chain can break down. Currently, about 85% of the IG used by Canadian Blood Services (CBS), and about 66% of the IG used by Hema-Quebec is made from plasma collected from paid donors mostly from the U.S. Based on the expert advice, we support CBS' efforts to establish a truly end-to-end Canadian supply of IG and attain 50% self-sufficiency.

Unfortunately, there is a group of vocal people who do not believe that CBS, or any entity acting on behalf of CBS, should ever pay a plasma donor. You should be aware that their view is not supported by the science, the numbers, or the modern-day reality of our conditions. They haven't brought realistic solutions to the table to address the significant needs of our patients.

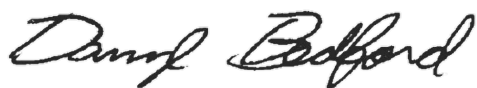
Fortunately, CBS has heeded the science and has heard the voice of our Foundation along with the other impacted patient groups. We're looking forward to finally having an IG supply from plasma collected here in Canada, fractionated in Canada, and provided exclusively to Canadian patients.

# ADVOCACY: SECURING THE CANADIAN SUPPLY OF IMMUNOGLOBULIN FOR OUR PATIENTS

Continued

I trust that you appreciated our brief statement on just one aspect of our advocacy. Whether you are a patient yourself or whether it is someone close to you, and no matter where you are in the patient journey, simply know that the Foundation is here working for you. We wish you all the best and hope that you enjoyed your summer.

Sincerely,



Darryl Bedford  
President

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## NEW BOARD MEMBER: HOLLY LONGSTAFF, PHD

Please join us in welcoming Holly Longstaff to the Foundation's Board of Directors!

Holly is the Director of Research Integration and Innovation at Provincial Health Services Authority of BC and a research ethics consultant. She is also an Adjunct Professor in the Faculty of Health Sciences at Simon Fraser University. She has worked as a consultant for Health Canada, the Public Health Agency of Canada, and the CIHR Ethics Office and her work has been published in a variety of journals including the CMAJ, Trends in Neurosciences, and Cell Stem Cell. Holly benefited greatly from the Foundation during her own experience with GBS and hopes that her background in research ethics will be able to contribute to the Foundation's research efforts.



# Community Awareness

## It Takes a Village

Our strong and mighty community made leaps and bounds in awareness efforts during the first part of 2024. The Foundation is in awe of your commitment to this critical endeavour across Canada. We are so proud of you!



We came out of the gate in early 2024 recognising International MMN (Multifocal Motor Neuropathy) Awareness month in February, the month which also marks Rare Disease Day. It's fitting these two initiatives align, as MMN, an ultra-rare disease, deserves to be highlighted along with other rare diseases. This initiated the release of of six Patient



Journey videos in February and March that tell the candid stories of our rare variant community. These videos were eventually released for our francophone community with voiceovers during the summer, and we welcome our francophone community to reach out to us if you'd like to participate in future interviews.

We lit the skies **blue** during GBS and CIDP awareness month with the new 'Light it Up for GBS and CIDP' campaign, and had GBS and CIDP Awareness Month proclaimed in forty-three municipalities, two provinces, and the month is permanently part of the Health Canada calendar.

The Foundation will host eight Walk and Rolls in 2024, the most ever held by the Foundation in a year.

We extend our sincere gratitude for every effort our community has made so far in 2024!



## From Blurry Vision to Virtual Immobility in a Day: Recovering From Miller Fisher Syndrome

Julio Castillo

One day in July 2019, I woke up with blurry vision. I could not distinguish the details of my wife's eyes, mouth, or nose. Imagine a portrait where somebody crosses many dark lines in the face until you cannot recognize the details. Two hours later I was seeing an identical twin image. An hour after that my right hand was paralyzed. Two hours later the whole arm was paralyzed and my left arm was weak. I began to lose my balance while walking. By late afternoon, I was in the hospital emergency room. By early evening my legs did not support me.

I had recovered from a gastrointestinal infection three days earlier, and the doctors thought my symptoms were associated. They admitted me, and for the next 48 hours I underwent electromyography, MRI, electrocardiogram, lumbar puncture, and uncountable blood tests. Then a doctor told me I did not have problems with my heart or brain, which was good news, and they had decided to treat my condition as Miller Fisher Syndrome (MFS), a spectrum of Guillain-Barré Syndrome. Miller Fisher first attacks the face and moves downward. They said the MFS developed from the previous gastrointestinal infection. It would not attack my brain and would not be lethal, but the effects on my nervous system and muscles might last for a year.

After several intravenous immunoglobulin infusions, doctors told me I was stable. I was happy with the good news and felt okay because, although MFS had me paralyzed, it would not kill me, and I would recover. I did not have pain or



*Julio Castillo retired in December 2022 after 30 years as an academic. He lives with his wife in Victoria, BC.*

lack of sleep. I felt lucky and had to focus only on my physiotherapy.

Two days later they transferred me to a rehab centre where I stayed for four weeks under regular medical supervision. My wife brought me fruits, yogurts, nuts, dark chocolate, and other healthy things to eat, and my children ensured that my insurance benefits were updated and that I paid my bills on time.

At the end of the month, I transferred to minimum medical supervision but intense therapy. My right arm was 100% immobilized, and my left arm 90% immobilized. I still had blurry and double vision, and my legs had movement but were too weak to let me stand.

After three weeks of working my legs with machines, I could stand up and walk using a walker. However, I had nodes on my calves that caused me cramps after walking 10 metres. In a distance of 50 metres, I had to stop three or four times. After weeks of walking, the cramps disappeared, thanks to the therapist who massaged the nodes in my calves. I still had poor balance and I could walk only with my walker. I could not use my arms and depended on nurses for eating and my wife for bathing and dressing. My vision remained the same. At the beginning of October, I became an inpatient in a specialized therapy centre, where I stayed for a month before becoming an outpatient. → **next page**

## From Blurry Vision to Virtual Immobility in a Day: Recovering From Miller Fisher Syndrome

### Continued

By November, my legs were working at about 50%, which allowed me to go without the walker for longer distance. I decided to walk for an hour a day. Walking seemed a miracle. On November 3, I woke up and my vision was normal— another gift. I remember that day because I had an appointment with my oculist for November 5 to design glasses to correct my vision.

However, therapists were losing confidence in recovering my arms. They told me about new technology that meant you could use a finger to drive a car and special devices you could put on your head to let you work a computer.

My new therapist was a specialist in arms and hands and had a different approach – massage. She worked intensively on many of the nodes inside my arms, rehabilitated my muscles, and I gradually regained the movements. It was painful, but I communicated well with her, and she knew when to stop. We trusted each other, and I followed her recommendations. For instance, I bought a machine that stimulated the muscles with electrical impulses. I decided to work two hours a day, including weekends. I walked one hour in the afternoon and worked on my hands for another hour in the mornings. During the day, I had hours of intense energy, then I felt exhausted and slept for two or three hours. In my mind, I felt that God was giving me another opportunity to have a whole life, but I had to work for it. Like a toddler I had to work hard to learn how to walk and eat for myself.

By February, I was driving my car and working on my computer. I could eat and bathe independently. My movements were awkward and needed a lot of

improvement, but I was self-sufficient. I kept working with my marvellous therapist until June, and my movements smoothed and I increased the range of angles and strength.

**I felt that God was giving me another opportunity to have a whole life, but I had to work for it.**

In November 2019, I could hold my phone. By June 2020 I was lifting four kilos with each arm. I finished my physiotherapy that month, but my neurologist had me in observation. I kept working two hours a day at home and sleeping many hours, and by August 2020, when my family doctor examined me, I was in good health. My neurologist also examined me at the beginning of August, and he released me. I was ready to work.

The doctors were right. It took me a complete year to be on my feet again. However, I had gained about 14 kilos due to the delicatessen that my family provided for me. I returned to work, but my right hand was still weak for certain activities, such as unlocking the door. My fingers could not do it, and I had to use my left hand and sometimes both hands. Specific movements with my right hand gave me cramps, and I also got cramps in my neck when exercising the upper part of my body. I was exhausted and slept close to 10 hours a day. The best way to handle the day was to take a 30-minute nap → **next page**

## From Blurry Vision to Virtual Immobility in a Day: Recovering From Miller Fisher Syndrome

### Continued

during my lunchtime. Sometimes, when driving to work, I felt sleepy. I wanted to return home to continue sleeping, and I had to stop for five minutes to recover. For several months, it was challenging to keep up with the day, but it became easier after each month. I got some hand-therapy devices to work my hands at work, and it did work well by improving strength and reducing the cramps.

In September 2023, I feel I'm back 100%, or close to it. I know my exercises and physiotherapy must continue almost every day. I also reduced my weight by 11 kilos, although I still enjoy the delicatessen provided by my family, just much less of it.

I am so grateful to my family and my friends who supported me emotionally through this time. I learned – and this lesson I want to pass on – that life is beautiful and worthwhile, but at least once in a lifetime, it hits you with a blow that can knock you down, and you have to fight back to recover the best you can. Every day, I projected myself into the future, thinking of all the beautiful things in life that were waiting for me: more memories with my wife, children, and grandchildren.

Good luck to everybody, and keep working.



*How Julio Castillo saw the street with MFS. (His wife was driving)*



*Now he sees it with normal vision.*



## WALK AND ROLLS - 2024

Interested in chairing or participating in a Walk and Roll? Go to [www.gbscidp.ca](http://www.gbscidp.ca) under Act Now. Email [info@gbscidp.ca](mailto:info@gbscidp.ca) or call 647-560-6842

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- REGINA** Sept. 21st
- EDMONTON** Sept. 22nd
- MONTREAL** Oct. 19th



# Walk and Roll: 2024 Fall Schedule

## Walk Schedule



Thank you to each volunteer Chair of our Walk and Rolls in 2024. Without you, these premiere events would not be possible. Chairs: Sharon Anderson, Darryl Bedford, Louise Desrochers, Nancy and Justin Galaski, and Jenny Rybie. To our community, thank you for walking, rolling, and your generous donations!

## Edmonton Walk and Roll - Sep 21st, 10 am

Rundle Park Picnic Site #5  
Registration 9:30 am

[Donate](#)

## Regina Walk and Roll Sep 21st, 10 am

Park next to to Northwest Leisure Centre - Registration 9:30 am

[Donate](#)

## York Region Walk and Roll - Sep 21st, 10 am

Fairy Lake Park - Registration 9:30 am

[Donate](#)

## Montreal Walk and Roll Oct 19th, 11:30 am

Carrefour Angrignon, the walk begins next to the Cafe Dépôt - Registration 11: 00 am

[Donate or Register](#)

## Similarities and Differences Between GBS and CIDP

**Steven K. Baker**

Peripheral Neuropathy Clinic  
McMaster University  
Dept. of Medicine  
Divisions of PMR & Neurology  
HHAC Chair in NMD



The category of dysimmune or autoinflammatory neuropathies is considerable and includes broadly ranging varieties such as vasculitic and paraneoplastic as well as demyelinating forms. Of the latter category, Guillian-Barre syndrome (GBS) and chronic inflammatory demyelinating polyneuropathy (CIDP) are, together, more common and better known. Both of these types of neuropathy induce damage to the Schwann cell processes (i.e., lamellae) that constitute the myelin. Generally, the antibody- and macrophage-mediated attack on myelinic antigens produces an asymmetric dysregulation of its primary function to insulate nerve impulses. This leads to disruption of electrical conduction and produces *conduction slowing* when mild to moderate and *conduction block* when more severe. This slowing and blocking of conduction, in its various manifestations, forms the basis for the electrophysiologic diagnosis (i.e., (1) terminal motor latency prolongation to  $\geq 150\%$  ULN, (2) CV slowing to  $\leq 70\%$  LLN, (3) F-wave latency prolongation to  $\geq 120\%$  ULN, (4) temporal dispersion:  $\geq 30\%$  increase of proximal vs distal negative CMAP duration).

Electrophysiologic evidence of demyelination is necessary and sufficient in CIDP, assuming other causes have been excluded, but neither necessary or sufficient in GBS. This is because early in the course of typical GBS (within 1 week of onset) the 'demyelination' may not have reached electrodiagnostic detection. Additionally, GBS of a mild extent and/or proximal distribution along with variants such as Fisher syndrome (i.e., ophthalmoplegia, areflexia, and ataxia) may manifest normal or non-diagnostic<sup>[a]</sup> electrodiagnostic findings. When GBS is suspected and early electrodiagnostic testing is unrewarding, repeat testing is recommended after week 2 from onset.

Onset determination is crucial for proper disease classification. The temporal kinetics of the disease play a major role in differentiating GBS from CIDP. GBS reaches its clinical nadir no later than 4 weeks while CIDP no sooner than 8 weeks. An ambulatory patient who did not require hospitalization may have difficulty differentiating between a continual decline between weeks 4 and 8, or beyond (CIDP), versus a decline to week 4 followed by stabilization without any frank recovery (GBS). Determining the timeline may seem trivial but is in fact key to the diagnosis if demyelination is confirmed electrodiagnostically. If the nadir is reached between 4 and 8 weeks an intermediary entity called subacute inflammatory demyelinating polyneuropathy is diagnosed. SIDP tends to be steroid-responsive and monophasic rendering it CIDP-like therapeutically and GBS-like temporally. It remains a somewhat debated entity.

[a] Not meeting criteria for acquired demyelination.

# Similarities and Differences Between GBS and CIDP

## Continued

Questions naturally arise when it comes to recurrent GBS (rGBS) and relapsing-remitting CIDP (rrCIDP). If the clinical nadir of acquired demyelination is  $\leq 4$  weeks then it is considered GBS until proven otherwise. If, after functional recovery has begun, there is another attack then the physician has to decide if this is a treatment-related fluctuation<sup>[b]</sup> as compared to rGBS or the first relapse of rrCIDP if enough time has passed between events. Technically, there is no clear answer to this other than a temporal analysis. A clinical decline early in the course of recovery but after a course of IgG is most likely a treatment-related fluctuation. However, if there was an immunogenic trigger like an infection or vaccination, rapid progression, or autonomic, respiratory, or cranial nerve involvement, then rGBS is more probable than rrCIDP. If these factors are not present and the decline is gradual, then rrCIDP is more likely. From a probability perspective rrCIDP would be considered more likely than rGBS. Therefore, in the case of a second event close follow-up should be provided. If a third event occurs the diagnosis becomes definite rrCIDP.

The 4-week demarcation of GBS has been complicated by the emergence of nodo-paranodopathies which, though classified as a subset of CIDP (for now) because they are chronic, can mimic GBS in terms of acuity. This is referred to as acute CIDP (aCIDP). Therefore, even if all the criteria for GBS have been met the final diagnosis may be a nodo-paranodal form of aCIDP (npCIDP). Acute CIDP tends not to manifest autonomic, respiratory, or cranial nerve involvement and the presence of these features would suggest GBS. Seropositive npCIDP patients, which constitute about 10-15% of all CIDP patients, harbour antibodies targeting contactin-associated protein-1, contactin-1, neurofascin-155, or neurofascin-186.<sup>[c]</sup> These patients develop a detachment and pulling away of their paranodal myelin loops from the axon. This delamination interrupts conduction of the electrical impulse at the node of Ranvier which leads to both weakness, from damaged motor nerves, and sensory loss, from damaged sensory nerves. The pathology in npCIDP does not involve macrophage-mediated demyelination. If treated early, npCIDP, can result in a fairly rapid improvement in symptoms. This appears to be due to the relative easier task of reattaching paranodal myelin loops as compared to the formal process of remyelination. This phenomenon is called reversible conduction failure (RCF).

Response to treatment also serves to distinguish between GBS, CIDP, and npCIDP. In general, while intravenous IgG antibodies are the therapy of choice for GBS and CIDP, there appears to be a more variable effect on npCIDP patients. Indeed, even in definite CIDP patients<sup>[d]</sup> some do not respond to IgG therapy at regular doses and require high-dose approaches. Additionally, steroids are useful in all forms of CIDP but are not indicated for GBS. More aggressive immunosuppression is often needed in CIDP proportionate to the severity of the disease. These agents could include mycophenolate mofetil,

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<sup>[b]</sup> This refers to a period of deterioration after initial improvement following sub-optimally successful treatment and reflects ongoing 'active' disease.

<sup>[c]</sup> NF-186 is a nodal antigen while CASPR1, CNTN1, and NF-155 are paranodal antigens. All patients with npCIDP harbour one of these antibodies. It is noteworthy that glial NF-155 and axonal CNTN1 bind to each other.

<sup>[d]</sup> Where there is no evidence for CMT1, POEMS or amyloidosis.

# Similarities and Differences Between GBS and CIDP

## Continued

azathioprine, or rituximab. In severe cases of acquired demyelination requiring hospitalization, plasma exchange (PLEX) is often chosen as the rapid elimination of pathogenic antibodies is believed to be a preferential mechanism of disease mitigation even though a landmark head-to-head trial established relative equivalence between PLEX and IgG. Finally, there may be a role for complement inhibition. but adequate trials have not been completed such that this form of therapy, though mechanistically appealing, has not been adopted as a feasible therapeutic option.

Recovery is highly variable ranging from atypical cases of almost immediate improvement (possibly secondary to early intervention or rapid RCF) to prolonged functional gains transpiring over several years in those patients with primary (i.e., AMAN & AMSAN<sup>[e]</sup>) or secondary axonal involvement. As GBS is, by definition, monophasic once a functional recovery has plateaued whatever deficits remain reflect the permanent sequelae of the neuropathy. It is important to note that the complete normalization of conduction velocities may not occur and is in fact not necessary to regain baseline sensory and motor function. It is not uncommon to have residual velocities that are surprisingly slow with the return of grade 5 or full strength in the previously affected muscles. Patients need to be aware of this and physicians need to provide reassurance. One's motor recovery is also contingent on rehabilitation. Indeed, from a clinical perspective it would be exceedingly difficult to discriminate between a patient who had full neurophysiologic recovery and another with 85% recovery who then achieved the last 15% through strength training. Contrariwise, with disabling disease even arduous strength training will not return normal function. Advanced age, rapidity of onset, severity of paralysis, and axonal involvement negatively correlates with recovery but does not preclude a satisfactory outcome.

There is no accepted nomenclature with regards to the descriptors for persistent symptoms after recovery from GBS or after CIDP that has remitted. The epithet, residual symptoms, is certainly adequate. Whatever descriptor is chosen it is essential that it communicate that the individual's current functional status is below that of their previous (premorbid) functional status. As noted above, this difference may be slight or significant. Whatever functional state is achieved it is important to remain active as exercise maintains the health of the motor units (i.e., the axon and all the muscle fibers it connects with). Residual symptoms do not intensify. However, residual symptoms may include exaggerated fatigability after exercise. Despite this fatigability, exercise represents the only means of overcoming the deficit in exercise tolerance. This paradox is generally underappreciated in GBS and CIDP patients, possibly because physicians do not clearly address this matter.

If, following a period of clinical stability in either recovered GBS or remitted CIDP<sup>[f]</sup>, there is a subsequent escalation of symptoms, whether that be motor or sensory or both it is necessary to

[e] Acute motor axonal neuropathy (AMAN) and acute motor sensory axonal neuropathy (AMSAN).

[f] This occurs in perhaps 15-30% of patients.

# Similarities and Differences Between GBS and CIDP

## Continued

have rapid follow-up. In this case the neuromuscular physician will determine if the increase in symptoms is related to worsening peripheral neuropathy or some other cause such as anemia, hypothyroidism, myositis, vitamin deficiency (B12 or D), insomnia, fibromyalgia or some other cause.

In summary, while the demyelinating features of GBS and CIDP do not inherently differ quantitatively enough to permit identification purely on the electrodiagnostic features, the temporal kinetics certainly do. The recent discovery of the nodo-paranodal forms of CIDP and their potential to present acutely implies that screening GBS patients may prove to be of clinical utility insofar as seropositivity connotes chronicity and a need for ongoing follow-up with rapid intervention upon recurrence. The future discovery of novel antibodies will ultimately refine the diagnostic sub-categories of both GBS and CIDP and hopefully lead to more targeted therapies which address the unique pathophysiologic features of each variant.

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# 📢 Announcement 📢



**November 9 -10  
2024**

## GBS/CIDP National Virtual Conference Free registration open now!

Don't miss out on this **free** educational programming for our patients and caregivers! For more details, click the register button. Here are some of the confirmed sessions:

- ★ What's new in inflammatory neuropathy? With Dr. Vera Brill
- ★ Care for the Caregiver with Jocelyn Gallagher
- ★ Ask the Experts Panel
- ★ ....and much more

**Click to  
Register**

## Neurological Health Charities Canada

### Canada needs an updated National Population-level Neurological Health Survey

July 31, 2024 - Aging, diversity and the realities of a post-pandemic society coupled with emerging trends in neurological research, diagnosis, and treatment present an unprecedented opportunity for collaboration and resolve. We are at a pivotal time when improved understanding about the neurological health of Canadians and their need for support can make a difference in health care planning for the future. To do this, Neurological Health Charities Canada (NHCC) proposes to collaborate with the federal government to develop a National Population-level Neurological Health survey for Canada. Read NHCC's Submission to the Federal Finance Committee's 2025 Pre-Budget Consultation [here](#).

Neurological Health Charities Canada (NHCC) is a coalition of organizations that represent people with neurological diseases, disorders and injuries in Canada. NHCC provides leadership in evaluating and advancing new opportunities for collaboration specific to advocacy, education and research to improve the quality of life for people affected by neurological conditions. GBS/CIDP Foundation of Canada became a member in 2022. As a member, we aim to ensure that conditions of the peripheral nervous system are a consideration for initiatives such as a National Population-level Neurological Health Survey.

## NEED SUPPORT?

Our support group meeting schedule is updated regularly on our [events page](#). Keep checking for upcoming meetings this fall.

If you require support outside a group setting, call 647-560-6842 or email [support@gbscidp.ca](mailto:support@gbscidp.ca)

The information provided in this newsletter is for educational purposes only and is not intended as a substitute for professional medical advice, diagnosis, or treatment. Always seek the advice of your physician or other qualified healthcare provider with any questions you may have regarding a medical condition. Never disregard professional medical advice or delay in seeking it because of something you have read in this newsletter.