Information published in this Newsletter is for educational purposes only and should not be considered as medical advice, diagnosis or treatment of Guillain-Barré Syndrome, CIDP, related neuropathies or any other medical condition.

Guillain – Barré Syndrome Support Group New Zealand Trust

Registered N.Z. Charity No. CC20639 Charities Act 2005

NEWSLETTER March 2019

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<td>ONZM, MD, FRACP, ChB</td>
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Trustee/ Board Member Vacancy

Due to the resignation of Dr. Pralene Maharaj there is a vacancy on the Board.

If you would like to offer your services to the Support Group as a Board/Trustee Member we would like to hear from you.

Contact the President or Secretary if you are interested and would like to know more.
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<tr>
<td>Dr. Gareth Parry</td>
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<td>ONZM, MB, ChB, FRACP</td>
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<td>Professor Emeritus, Department of Neurology, University of Minnesota, USA.</td>
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<td>Dr. Chris Lynch</td>
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<tr>
<td>Neurologist and Neurophysiologist at Waikato Hospital</td>
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<td>Honorary Senior Clinical Lecturer at the Auckland Medical School Waikato Campus</td>
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<td>Dr. Annette Forrest</td>
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<td>ICU Consultant</td>
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<td>MBChB, BPharm, Dip ag &amp; Vet Pharm</td>
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<td>PGDIP aeroretrieval</td>
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<td>CAA Medical Examiner</td>
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<td>PGDIP Occupational Health</td>
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<td>Dr. Suzie Mudge</td>
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<td>Director &amp; Physiotherapist Neuro Rehab Results</td>
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<td>Senior Lecturer/Senior Research Officer</td>
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<td>Health and Rehabilitation Research Institute, AUT University</td>
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<td>Dr. Dean Kilfoyle</td>
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<td>Neurologist Auckland City Hospital</td>
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<td>Auckland District Health Board</td>
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<td>Dr. Vic du Plessis</td>
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<td>Neurologist and rehabilitation specialist.</td>
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<td>Part time consultant neurologist Dunedin</td>
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<td>Ben Scrivener</td>
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<td>Senior Neurological Physiotherapist – Auckland DHB</td>
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<td>BHSc Physiotherapy NZRP</td>
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<td>Dr. David Gow</td>
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Editor’s Note

It’s been a great summer so far which I hope you have all been able to enjoy. There have been a few new cases of GBS/CIDP reported to us and where possible we have been in contact with these people. It is still an ongoing struggle to find out about these cases early in the onset, but our hospital visitors are working hard to improve liaisons with various hospitals.

Our big calendar event of 2019 is rapidly approaching. If you haven’t registered for the conference please do so. It is a great opportunity to hear and speak to the members of our Medical Advisory Board and to meet other survivors who ‘get’ what you have been through.

We welcome Ben Scrivener to the MAB. He has replaced Kathryn Quick. Ben is a Senior Neurological Physiotherapist at Auckland District Health Board.

As I mentioned in the last newsletter I would like to pass the job of Editor on. If you would like to take this on please email me or put your hand up at the AGM/Conference.

Thanks to everyone who has contributed to the magazine over the past year. To those regular contributors thank you for getting your pieces to me on time, (even though on occasion I have deleted them accidently). Special thanks to the members of the Medical Advisory Board who have taken the time to supply very interesting articles.

It would be nice to hear how the various coffee groups around the country are going, as I’m sure it’s not only the BOP/Waikato who are enjoying these.

Our cycling group is proving quite popular. I’m still unsure if the drawcard is the ride or the amazing shared lunch that appears afterwards. I know for my hubby it’s the lunch as he isn’t really a cyclist. But as he said they are such a great bunch of people I enjoy coming along.

And I think that is the glue that holds this support group together, so get yourselves along to the conference and join in the fun.

Chris

President’s Report

After a very long summer the whole country has experienced, personally we had three weeks on the Hibiscus Coast, enjoyed the beach each day.

It was a different January for us, our daughter, her husband and our grandson left for Australia, for employment promotion, however we gained our youngest son back from the UK.

I hope you all had a relaxing festive season, and managed to get a break at some stage.

We are having to come to the realisation that our bi-annual conference and AGM is fast approaching. The committee has been working very hard in the back ground to bring together all the different organisations this type of event requires.

As President, I urge all GBS CIDP sufferers, care carers and professional persons to seriously consider attending this conference and AGM.

It is one of the few opportunities to gain access to the medical advisory board and gain invaluable support from each other.

The combined knowledge at these conferences continues to exceed any other options of sourcing advice and support that we need to attain satisfactory outcomes in our recovery processes.

The registration and details about the conference are in this newsletter.

For these conferences to continue to be viable we do require a strong representation of our members.

I look forward to seeing and catching up with as many of you as possible in Hamilton at the end of April.

Doug Young
One of the reasons Vivienne and I settled on the Nelson region as our base in New Zealand when we immigrated nearly 20 years ago was its reputation for a good climate and warm weather and (usually) the annual sunshine record holder and it has so proved to be BUT things went somewhat over the top heat-wise a couple of weeks back when we had our biggest forest fire in the region since we arrived. It has been well reported on the news so I won’t dwell on the details but it did impact on the lives of our younger daughter and her family who live in Wakefield and were evacuated out of their house for nearly 3 weeks – fortunately we were on holiday in the North Island so our house in Mapua was available so they were not on the streets. Now I consider my daughter a pretty level headed and organised lady both professionally and domestically but once they were allowed back into their house (fortunately undamaged) she admitted to me it had probably been the most stressful thing that had happened to her for many years. Although I have no absolute proof I put down my own brush with GBS to stress caused by my job at the time and I wonder just how many other GBS cases that cannot be linked to the obvious triggers may have been conditioned by stress. In breaking news we have just learned that one of the volunteer firemen who came up from Christchurch and worked, along with his colleagues, hugely long and difficult hours in terrible conditions has just succumbed to GBS and is in Hospital. One of our local AHV’s is trying to make contact with him and whilst at this time we do not know what triggered his attack I am pretty certain it will turn out to be a stress related issue.

A more practical consequence of the fire was the financial impact on our daughter’s family. Apart from one 5 minute visit made by her partner (accompanied by a police officer) to collect medication and turn off electric fences and open gates so the stock could stand a chance if the fire reached them they were cut off from their ŏin house ŏtramping gear business ŏonline orders still coming in but with no access to stock they could not be fulfilled and also their ŏAir B&B accommodation was naturally not functional. Whilst their financial loss will be manageable there was no compensation available to them and in just the same manner when GBS strikes the family wage earner there is no safety net of any significance to replace the lost income and as many of our members know the ŏdown time ŏis usually a LOT more than 3 weeks.

The Conference is barely 6 weeks away so now is the time to make your mind up and register your attendance œI œve said it many times before but make no apology for saying it again œ you will NOT regret attending. Our Patron Steve has set aside her Mayoral duties and will be with us all weekend and we have a full complement of our Medical Advisory Board who, in addition to imparting their knowledge generally in their speeches are more than happy to deal with one on one questions during the breaks something that would take forever to set up through ŏthe system œ

Subject to some final checks the website sub-committee are set to press the green button to make the site live. There will be no change to our website address just a whole new format and capabilities. We know we will not have got things 100% right and are relying on your feedback if you spot any glitches or gaps - just let me know and I can pass on the information to Matt our website guru.

In a past Newsletter we had a member report on the assistance to his recovery provided by following the Reike practice. I have had another contact from a practitioner based in the Wellington area suggesting that Zero Balancing Sessions may be beneficial to those recovering from GBS œdoes anyone have any actual experience of receiving Zero Balancing and, if so, did you think it was beneficial?.

Well that’s all from me for now œ see you in Hamilton

Take Care
Tony
My neurology training began in Wellington NZ with Dr Richard Hornabrook (snr) and later Drs Haas, Abernathy and Mossman.

Later, I became interested in peripheral nerve disorders including basic science research during my formal neurology training in Dunedin under Martin Pollock and Graeme Hammond-Tooke. Clinical nerve disorders and clinical, neurophysiological and nerve biopsy were the strengths of the Dunedin Neurology unit, which remained a national referral centre for these disorders up to the early 2000s.

Basic science of nerve disorders was the Dunedin Medical School sub-specialty. Professor Pollock, and Drs Hammond-Tooke and Nukada were engaged in research spanning experimental diabetic neuropathy, heat and cold neuropathy and ischaemic neuropathy. Dr Nukada supported my MD studies examining experimental neuropathy from burns, that set the course for my overseas advanced training. In Oxford UK I worked for Dr Michael Donaghy, but my passion for peripheral nerve diseases was fostered by Prof Peter Dyck and his team at the Mayo Clinic. Again the environment focused upon clinical and scientific peripheral neuropathy research focusing on inherited diabetic and acquired forms of this disease.

At the Mayo Clinic I learnt the quantitative clinical evaluation of peripheral neuropathy measuring motor and sensory impairments to research precision. This was complimented with EMG, quantitative sensory testing and autonomic function laboratory testing. These skills were assembled as I completed peripheral nerve and EMG fellowships.

During this time I worked on a project correlating quantitative sensory testing with conventional nerve evaluation studies.

Quantitative sensory testing is a machine test of sensation. It measures small intermediate and large sensory nerves. It measures vibration sense, cold perception and pain. These are not well tested with usual NCS. These nerves are often the first affected in neuropathy and are involved in the pain and blood pressure and fast heart rate problems in GBS. QST testing is not used in NZ, but is a part of conventional testing at large academic centers in Australia, USA and Europe.

Why is sensory testing in Guillain-Barré syndrome important?
Sensory impairment is the first and last symptoms of GBS. This might seem a controversial statement at first reading.

Guillain-Barré syndrome was renowned as a demyelinating weakness (motor nerve) problem. The sub-types of GBS has broadened to include well known and lesser known sub-types, including axonal forms such as acute motor-axonal neuropathy (AMAN) which affects motor nerves exclusively; acute motor and sensory axonal neuropathy (AMSAN) with includes the sensory and motor nerves and inflammatory sensory neuropathy affecting the proximal sensory nerves in the spinal canal (rare, normal nerve studies, abnormal evoked potentials).

Each of these forms of GBS exhibit a variable degree of sensory (pain, loss of sensation) and autonomic nerve impairment (loss sweating, low blood pressure, abnormal heart beat) along with motor nerve impairment (weakness).

Whilst the earliest symptoms of Guillain-Barré syndrome are often sensory including pain, numbness and autonomic nerve dysfunction, the major disabling symptoms leading to medical attention is weakness, representing motor nerve impairment. This becomes a predominant focus of life preserving treatments in Guillain-Barré syndrome. This may involve treatments administered in the ward and, when severe, in the intensive care unit, principally to manage weakness symptoms.

From a patient's point of view, whilst these symptoms are alarming, it is the pain and sensory impairment which is equally distressing in the acute and intermediate and late phases of GBS. Much of the symptomatic impairment experienced by patients can be attributed to impairment of the smallest nerve fibres which can affect nerves to the gut and bladder; and limb sensory nerve fibres. In the initial stages severe pain may be prominent.
Sensory Testing in GBS

Dr. Chris Lynch

Whilst the curative treatment for Guillain-Barré syndrome is directed towards the motor nerve impairment, but it is the sensory and autonomic impairment which produces considerable malaise in the acute and intermediate period. The importance of sensory symptoms is highlighted by the persistence of symptoms of Guillain-Barré syndrome after the initial recovery of motor impairment; this has been surveyed in children with Guillain-Barré syndrome as well as adults; documenting that up to 38% have numbness and tingling, 24% may have painful hands and feet, and 37% are unsteady in the dark, suggesting impairment of sensory nerves. There is a considerable degree of fatigue, 22% in children and often much higher in adults; though this has not been clearly attributed to sensory nerve impairment.

Sensory nerve testing for Guillain-Barré syndrome predominantly relies on symptoms and quantitative clinical examination. These are time honored and quantitative techniques. Nerve conduction studies can provide important information regarding the sensory nerves to differentiate sub-types of Guillain-Barré syndrome ie: AMAN from AMSAN but these tests are not sensitive to most of sensory and autonomic fibre impairments as these are not tested by standard nerve conduction studies. QST is one of a number of other sensory nerve testing modalities which can be used in selected case to measure sensory nerve functions. These include evoked potential tests, which look at the most proximal part of sensory nerves in the spinal canal before it joins the spinal cord; skin biopsy looking at the smallest nerve fibres within the dermis using histological techniques, and nerve biopsy which examines large intermediate and small sensory nerve fibres. Nerve biopsy techniques are currently performed by large academic units in Australia and centres in Europe and the USA. These are not performed in a quantitative fashion in New Zealand currently.

Is there any value in changing sensory nerve testing in GBS?

This question is likely to generate debate amongst the medical board of our society. I raise it to promote discussion to address the symptoms of GBS patients especially in the acute and chronic phases of this condition.

Whilst the principal impairment in acute GBS is weakness and its effect on mobility and respiration, we do not routinely evaluate the small sensory nerve fibres or the autonomic nerve fibres in a quantitative fashion. Our current treatments are directed towards improving strength (motor nerve function) with immune treatments, typically plasma exchange or intravenous immunoglobulin. Monitoring improvement is largely based on return of strength (respiratory function and limb movement)

For the medium to long term GPS patients it is sensory and autonomic function, paresthesia, pain and unsteadiness which impairs function. Currently we do not measure this serially, and our treatment directed toward this nerve impairment is symptomatic.

We do not routinely measure the sensory autonomic function of our patients in a sensitive and quantitative fashion and thus our ability to know how this changes or what effect our current treatments (plasma exchange or IVIG) have on this important aspect of the GBS syndrome might be. Perhaps accurate measurements of sensory nerves will allow us to devise treatment paradigms which can reduce the 24-37% of patents with ongoing sensory symptoms. Effective treatment may be identified through treatment trials using sequential sensitive sensory clinical observations.

Whilst we have no curative answers for those patients and family members who have ongoing sensory symptoms, this commentary may help raise discussion amongst the community and medical board who share a passion for these conditions.
Tis now been 30 years, and I remember the day well when I got my diagnosis as to why I was like I was, indeed, why I had been under the weather for a year and the doctor couldn't figure out why - the neurologists said simply, Guillain Barré Syndrome. I probably should have been hospitalised, certainly I should have been diagnosed a year earlier than I was, but, that was the way it turned out for me. The ten years following were marked with unusual and almost continual intense pains, particularly in my lower legs and yet sometimes throughout my body. And when I found others with similar diagnoses, I remember well how good I felt when I joined with those others to share . . . . for no one else really seemed to "understand" if that is the right word.

Now, 30 years later, the twinges sometimes return, especially on waking, whether from sleep or an afternoon nap - my body stiffens and locks in place, with feelings and sensations akin to the glissandos of a piano player, perhaps Cage or Satie or Glass with their minimalist versions of music, racing back and forth, up and down, inside and out, especially the lower legs, but sometimes further. I can, fortunately, stretch, exercise, move about and rid myself of those symptoms now, which is certainly better than 20 years ago when I could not, I could only endure. Crying helped back then. And every now and then what I call a flying electron travels from one point to another in my body - almost like the star bursts of the past when something triggered a nerve that sent weird messages astray - now much reduced from what was. And yet, occasionally when waking the old body is caught in a whirlpool of flow, of waterfall feelings that flash through, and I am able now to laugh and recall with happiness how it used to be rough, not just a minor key worthy of note but no longer of distress.

Yet still, even with 30 years experience, the surrounding lack of understanding continues . . . family, neighbours, community, medical specialists and the health care folks, friends and those I call potential friends who are quite really strangers . . . they just don't understand the strange symptomatology that I have, that I assume some others with a GBS diagnosis may have . . . perhaps some do, perhaps some don't but that is the closest group of folks who might know about all that . . . we are an unusual lot, having had profound and at the time terrifying happenings . . . that we have had to struggle to overcome and manage and remarkably, then move on and keep moving on . . . Some of my situation could be related to old age, for I am now 80, but surely some is that GBS that hangs on, like a cat playing with a mouse, letting it get almost out of reach, then grabbing and setting a boundary . . . where complete escape is difficult, even impossible, to attain. I look just fine, so friends tell me, and that is true most of the time for I do feel just fine, but every now and then, that cat's paw reaches out, gently cuffs me, holds me, and lets me know that yes, I am different - I am a survivor of GBS and I am now very STRONG and I can and will MANAGE . . . and I thank the GBS Group of New Zealand - keep on keeping on

kia kaha . . . . Bob Gregory (Life Member)
CIDP is a chronic neuropathy that shares many characteristics with Guillain-Barré syndrome (GBS). Both are neuropathies caused by inflammation of peripheral nerves resulting from an attack of the immune system, mainly targeting the myelin sheath. The principal difference between the disorders is the temporal evolution; GBS reaches its nadir within 4 weeks while CIDP, as the name implies, evolves over many weeks or months. CIDP may run a steadily progressive course or may have recurrent relapses; i.e., attacks that cause rapid deterioration but following which complete or partial recovery occurs.

It has long been suspected that CIDP is not a single, monolithic disease. Individual patients are affected quite differently. Most patients have predominantly motor manifestations with proximal (close to the body) and distal (hands and feet) weakness while in others the manifestations are predominantly sensory with numbness, pain and loss of balance. Some evolve rapidly, over a period of a few weeks or months while others develop and progress slowly. In some the disease is mild with little more than annoying symptoms while others experience a severe debilitating disease.

Like GBS, CIDP is an eminently treatable disease but treatment responses also differ. There is no consensus as to the most effective treatment; steroids (prednisone or some similar medication), immune globulin administered intravenously (IVIg) or subcutaneously (under the skin, SQIg)) and plasmapheresis are all effective and each has its proponents. As a general rule, there is no persuasive evidence that one form of treatment is superior to another and the choice of treatment is usually based on cost, adverse effect profile, convenience and the personal preferences of patient and physician. In NZ, steroids and IVIg are the most frequently prescribed while in the US the vast majority of patients are treated with IVIg. However, it is well recognized that individual patients respond differently to different treatments so if one treatment fails it is imperative to try another. Occasionally, chemotherapy with drugs such as azathioprine (Imuran), cyclophosphamide (Cytoxan) and rituximab (Rituxan) are used but their benefit is uncertain and some are expensive and Pharmac often declines payment for these treatments. Inevitably in this day and age, bone marrow or stem cell transplants have been used with occasional reports of benefit.

In CIDP it is thought that antibodies may attack specific components of the nerves and that the different forms of the disease may reflect different antibody profiles. However, identification of specific antibodies has proved elusive until recently. As shown in the figure, the myelin sheath wraps around the axon, the electrical cable that transmits messages.

The sheath consists of blocks of myelin separated by narrow gaps called the node of Ranvier. The region of the axon alongside the node is highly specialized and contains a suite of many complex proteins that are essential for the normal passage of the electrical signals. Recently, antibodies to some of these proteins have been identified in some CIDP patients. These CIDP patients had a predominantly sensory form of the disease with prominent problems with balance and often a marked tremor and disease course was more rapid and the disability more severe.
Chronic inflammatory demyelinating polyradiculoneuropathy (CIDP): a multifaceted group of diseases.  
Dr. Gareth Parry

Why should we care? There is, of course, the scientific imperative to understand CIDP better, but more importantly for patients with CIDP the response to treatment is different. Patients with these antibodies do not respond to IVIg and the response to steroids is less assured than it is with forms of CIDP who do not have these antibodies. IVIg is an extremely expensive treatment that is not without risk and identification of the antibodies would obviate the need for a trial of this treatment. A trial of steroids may be warranted but if response is not seen quickly transition to a more effective treatment should be considered. This is a subset of CIDP patients who do respond to treatment with rituximab. Although rituximab is expensive it is a lot less expensive than IVIg and I have been able to persuade Pharmac to approve this treatment for patients with highly specific antibody profiles. Thus, if a CIDP patient has a rapidly progressive disease with predominantly sensory symptoms, problems with balance and tremor it is imperative to obtain assay for these specific antibodies. Such assays are available at several laboratories around the world and, although expensive, are much less expensive than wasting money on treatment with IVIg.

HAVE YOU REGISTERED FOR THE CONFERENCE YET?  
Reasons why you should:

1. A great opportunity to meet fellow survivors of GBS/CIDP  
2. Here the latest developments in treatments  
3. Listen to interesting presentations from members of our Medical Advisory Board.  
4. Get to speak to these members one on one  
5. Find out ways you can help the group. i.e. become a hospital visitor, fill any vacancies on the board, organise a coffee group meeting in your area.

Time is running out. Please fill out the form attached to this newsletter and send to our Treasurer.

If you can’t commit to the whole weekend just come along for the Saturday. You won’t be disappointed.
We have enjoyed two lovely bike rides from Leamington to Lake Karapiro over the last couple of months followed by two sumptuous shared lunches. Beautiful sunshine and nice company, what more could one want!!

Left: January Ride Lake Karapiro
Fran and Grant McKay, Rex and Linda Bannister, Barry and Judy Deed

Right: February Ride Lake Karapiro
Meike Schmidt-Meiburg, Judy Deed, Fiona Green, Barry Deed, Grant and Fran McKay
Conference 2019 and AGM

This is early notification as the Hotel has a new system and will not be holding accommodation in block for us as it has done in the past. They shouldn’t run out but the earlier you book the better.

VENUE: Ibis Hamilton Tainui, 7 Alma Street Hamilton

DATES: 26th – 28th April 2019 (the weekend after Easter)

To book accommodation at the Ibis (or Novotel, 18 Alma Street) go to the following link:

https://accorconferences.co.nz/custom-offers/gbsnz-conference-2019

You will need to book your accommodation promptly to ensure you get the special Conference rate.

Any queries please contact Peter Scott: peterrwscott@gmail.com

An interesting program will be arranged with the format similar to previous conferences.

Registration form in this magazine and on the web site.

Bay of Plenty Waikato Coffee Group Get Together

When: Thursday 23rd May
Where: Willow Glen Café
934 Gordonton Road, Gordonton
Time: 11.00 am onwards

Please let me know if you are coming by the 20th May so I can confirm numbers with the café. Check out their website and menu.

http://www.willowglen.nz/menus

You can order from the menu or get something from the cabinet.

Confirm with Meike:
Cell: 027 325 0369, Ph: 07 867 3163
Email: schmidtfarm@xtra.co.nz

EVERYONE WELCOME

Auckland Coffee Group Get Together

When: 7th April
Where: 35 De Havilland Road, Hobsonville
Time: 2pm onwards

Contact: Eileen
Cell: 021 1133607
Email: eileennagnajacobsen@hotmail.com

All welcome, whether old friends, new or just visiting.
Ride Offered to Conference

Our President Doug Young has two spare seats to the Conference. Available Wellington to Hamilton and return.

Contact Doug if you are interested
Ph: 03 2304060
Email: deyoungs@xtra.co.nz

URGENT HELP WANTED

In order to complete one section of the new website we need to include a few comments from members about the help and support you received from the Group when you were ill and subsequently. If you could drop our Secretary, Tony a few lines (literally no more than 2 or 3) about your experience with the Support Group and if you are happy to do so, include a photo of yourself that would be much appreciated.

This is needed by the 17th March at the latest.

Email Tony at:
tonypearson@xtra.co.nz

Want to receive your newsletter in colour? Receive it by email and save a tree. Please contact the Editor to update your delivery option.
GUILLIAN BARRÉ SYNDROME SUPPORT GROUP NEW ZEALAND TRUST
2019 CONFERENCE AND ANNUAL GENERAL MEETING AT THE IBIS HOTEL HAMILTON 26-28 APRIL 2019

I/We will be attending the Conference as follows

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<td>Hospital Visitors Meeting</td>
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<td>Wine, Cheese and Chat</td>
<td>5.30pm-7pmish</td>
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<td>SATURDAY 27th Apr</td>
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<tr>
<td>Conference</td>
<td>9.00am to 4.00pm</td>
</tr>
<tr>
<td>Conference Dinner</td>
<td>7pm</td>
</tr>
<tr>
<td>SUNDAY 28th Apr</td>
<td></td>
</tr>
<tr>
<td>Annual General Meeting</td>
<td>10am</td>
</tr>
</tbody>
</table>

REGISTRATION COSTS

If paid by 18-Mar-19

- Full Registration $100
- Saturday Only $80
- 2nd Family Member Saturday Only $50
- Full Time Students $30
- Saturday Dinner (Optional) $45 ph
- TOTAL $_________

Special Dietary Requirements (ie GF etc) Please advise _________

ARRIVAL METHOD & ESTIMATED TIME

- Friday/Saturday/Sunday (Please circle which day)
- Estimated time of arrival ________am/pm
- Method Car/Plane/Other (Please circle one)

PLEASE NOTE THAT YOU WILL NEED TO MAKE YOUR OWN HOTEL BOOKINGS DIRECT.

The Hotels have a new system and will not be holding accommodation "in block" for us as in the past, they shouldn’t run out but the earlier you book the better.

- Ibis 7 Alma St Hamilton $130 per room only per night
- Novotel 18 Alma St Hamilton $180 per room only per night

to book either online go to www.accorconferences.co.nz/custom-offers/gbsnz-conference-2019

and indicate the hotel you wish to book into

If you need a disabled room please advise hotel at time of booking.

Are you interested in sharing a room? Please advise if you are

Is this your first Conference Yes/No (please indicate)

Who is the sufferer? __________________________________________

Who is (was) the carer/spouse __________________________________

NAME _______________________________________________________

ADDRESS _____________________________________________________

E-Mail Address _________________________________________________

Given Name (Nick) name (s) for name tags _________________________

PLEASE RETURN TO GBS PO BOX 4162 PALMERSTON NORTH 4442 WITH YOUR PAYMENT.
IF PAYING BY DIRECT CREDIT INSURE THAT YOU INCLUDE YOUR SURNAME IN THE REF BOX AND SEND THIS FORM TO THE ABOVE BOX NUMBER.
BANK DETAILS ARE TSB BANK MOTOUROA BRANCH NEW PLYMOUTH A/C NO. 15 3949 0339362 00