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MDJunction Cirrhosis Support Group Newsletter

MDJunction

PEOPLE HELPING PEOPLE

Facebook Initiative Leads to Tenfold Surge in Online Donor Designations; Surpassing 33,000 in First Six Days

RICHMOND, Va. - May 11 - Donate Life America, the national organization dedicated to increasing the number of registered organ, eye and tissue donors who save and heal lives, reported that online donor designations increased tenfold during the six days following the announcement of Facebook's organ donation initiative.

Facebook's upgrade to its Timeline profile structure, which allows Facebook users to declare and share their organ donor status, features a link to Donate Life America's National Registration Page, which in turn enables individuals to legally designate their donation decision on a state donor registry. As a result, state donor registries across the country reported a surge in online registrations that was ongoing six days later.

Press Release

Forty-six donor registries reported a total of 33,406 online donor designations in the first six days of the Facebook initiative, more than ten times typical enrollment activity which averages 548 per day. (See data table.) The first two days showed the most dramatic upswing with 24,367 enrollments, with another 4,350 joining on May 3. Daily totals for the next three days were 2,230 and 1,020 and 1,149, revealing more than double the typical level of online activity on the initiative's sixth day.

"While a sustained, virally-supported surge in online donor designations will add hundreds of thousands to the nation's donor rolls over time, we are eager to measure the impact at motor vehicle agencies, which historically account for 98 percent of registry enrollments," said David Fleming, President and CEO of Donate Life America.

Accurate measurement of the impact at motor vehicle agencies is not possible at this early stage, as few agencies are able to immediately report donor designation activity, and daily variations in customer traffic and transactions make comparisons with long-term averages difficult. A comparison of donor designation rates between the first and second quarter will provide a more accurate comparison.

"We encourage all Facebook users who declare their intent to donate on their profile to legally authorize their decision by signing up on their state donor registry," said Fleming. "Taking that step will provide hope to the over 114,000 men, women and children currently waiting for a life-saving organ transplant."

To find out more about Donate Life America or to register to be an organ, eye and tissue donor, visit www.facebook.com/DonateLife.

Disclaimer:

We are **not** doctors! Always consult with your own physicians before making any changes to your treatments.

We are **not** lawyers! Get appropriate legal advice when it is necessary.

We aren't even experts! We are patients and former patients that have been doing our own research on our common disease, trying to help other travelers on the roller coaster of dealing with cirrhosis.

State Registry	Total 5/1-5/6	% of Avg	May 1	May 2	May 3	May 4	May 5	May 6
Alabama	62	1,033	18	27	7	3	1	6
Arkansas	67	1,117	15	30	13	6	2	1
Arizona	746	829%	328	225	111	37	22	23
California	4,917	1,171	2,001	1,673	585	286	170	202
Colorado	386	1,608	171	139	36	26	5	9
DC	173	961%	93	39	26	9	5	1
Florida	2,280	380%	822	716	313	204	97	128
Georgia	1,012	5,622	376	405	104	75	17	35
Hawaii	22	367%	8	6	4	2	1	1
Iowa	856	2,038	411	279	92	23	27	24
Idaho	62	1,033	15	20	19	4	3	1
Illinois	1,186	2,824	540	373	150	67	24	32
Indiana	756	1,400	298	255	128	44	20	11
Kansas	719	2,397	291	263	89	43	15	18
Kentucky	130	433%	75	34	7	5	3	6
Louisiana	407	2,261	167	149	48	24	11	8
Maryland	619	1,032	239	208	101	36	15	20
Michigan	1,174	356%	439	333	197	98	41	66
Minnesota	899	3,746	285	381	127	59	21	26
Missouri	751	1,788	344	220	107	47	12	21
Mississippi	328	1,367	61	150	74	19	15	9
Montana	74	1,233	30	21	14	5	2	2
North Carolina	1,220	1,130	578	407	116	43	29	47
Nebraska	525	1,458	226	187	65	22	10	15
New Mexico	122	1,017	42	48	12	14	2	4
Nevada	242	2,017	86	90	45	9	2	10
New York	1,654	1,622	764	549	145	100	55	41
Ohio	697	465%	241	232	97	61	29	37
Oklahoma	320	2,667	129	111	37	22	10	11
Oregon	602	2,508	306	184	46	33	20	13
Pennsylvania**	58	322%	24	18	6	7	2	1
Puerto Rico	98	136%	18	31	13	12	12	12
South Carolina	398	1,327	142	142	58	36	8	12
Tennessee	281	781%	92	129	27	19	11	3
Texas	3,224	896%	1,252	1,080	412	245	118	117
Utah	447	931%	139	132	127	28	11	10
Virginia	917	1,698	217	403	171	85	24	17
Washington	419	1,397	185	126	52	32	9	15
Wisconsin	1,408	903%	566	487	160	106	41	48
Wyoming	43	717%	10	18	6	5	1	3
New England*	3,105	2,250	1,010	1,283	403	229	97	83
TOTAL	33,406	1,016	13,054	11,603	4,350	2,230	1,020	1,149

Visit or Contact us (please!) via:

www.mdjunction.com/cirrhosis

www.MySickLiver.weebly.com

E-mail: MySickLiver@gmail.com

We're also on

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U.S. Department of Health and Human Services
HRSA Health Resources and Services Administration
OPTN Organ Procurement and Transplantation Network

UNOS Liver Allocation Policy (Abridged)

UNOS DONATE LIFE
UNITED NETWORK FOR ORGAN SHARING

What are the special statuses for liver allocation?

The only priority exceptions to MELD are the categories known as Status 1A and 1B. Status 1A patients have acute (sudden and severe onset) liver failure and a life expectancy of hours to a few days without a transplant. Status 1B is for very sick, chronically ill pediatric patients (age less than 18). Certain pediatric patients initially receive a PELD (less than 12 years old) or MELD (12-17 years old) score of 30. If the candidate does not receive a transplant within 30 days of listing with a MELD/PELD of 30, then the candidate may be listed as a Status 1B. Less than one percent of liver transplant candidates are in these categories at any one time. All other liver candidates age 12 and older are prioritized by the MELD system.

Why do we use MELD/PELD?

Until 2002, patients needing liver transplants fell into four medical urgency categories. The categories were based on a scoring system that included some laboratory test results and some symptoms of liver disease. One concern with using symptoms in scoring was that different doctors might interpret the severity of those symptoms in different ways. In addition, this scoring system could not easily identify which patients had more severe liver disease and were in greater need of a transplant. Research showed that MELD and PELD accurately predict most liver patients' short-term risk of death without a transplant. The MELD and PELD formulas are simple, objective and verifiable, and yield consistent results whenever the score is calculated.

How are livers allocated?

First a selection of all the people currently waiting for an available liver narrows the possible candidates to a "short list" by matching certain physical characteristics such as blood type, height, weight, etc. Then, each candidate on the short list receives an offer of the available organ in a specific sequence. Partly because pediatric transplant candidates (younger than 18) need smaller organs, they will receive priority in the liver offer sequence. Pediatric donor livers are first offered to pediatric patients. Liver allocations occur in the following sequence until finding a matching recipient. Given the shortage of qualified donor livers, a match **will happen**!

1. To the most urgent **(Status 1A)** ***pediatric (ages 0-11)*** candidates located in the **same UNOS region** as the donor
2. To the most urgent **(Status 1A)** ***pediatric (ages 0-11)*** candidates located **across the country**
3. To the most urgent **(Status 1A)** ***adolescent (ages 11-18)*** candidates located in the **same UNOS region** as the donor
4. To the most urgent **(Status 1A)** ***(ages 11-18)*** candidates located **across the country**
5. To the most urgent **(Status 1A)** ***adult*** candidates **local (same OPO)** to the donor
6. To the most urgent **(Status 1A)** ***adult*** candidates located in the **same UNOS region** as the donor
7. To the most urgent **(Status 1B)** ***pediatric*** candidates located in the **same UNOS region** as the donor
8. To ***pediatric candidates (ages 0-11)*** that are located in the **same UNOS region** as the donor in order of decreasing PELD scores
9. To the most urgent **(Status 1B)** ***adolescent (ages 11-18)*** candidates located in the **same UNOS region** as the donor
10. To the most urgent **(Status 1B)** ***adolescent (ages 11-18)*** candidates located **across the country**
11. To candidates who have a **MELD/PELD score ≥ 29** that are **local (same OPO)** to the donor
12. To **liver-intestine** candidates **across the country** in descending order of mortality risk scores
13. To candidates who have a **MELD/PELD score between 15-28** located in the **local (same OPO)** as the donor
14. To candidates who have a **MELD/PELD score greater ≥** in the **same UNOS region** as the donor
15. To candidates who have a **MELD/PELD score < 15** are **local (same OPO)** to the donor
16. To candidates who have a **MELD/PELD score < 15** located in the **same UNOS region** as the donor
17. To candidates located **across the country** in order of decreasing MELD scores

When are extra points added to MELD scores?

Certain conditions influence the life expectancy of liver disease patients. These conditions generally do not affect the MELD/PELD calculation. The following is a partial list of the conditions that warrant increasing the MELD/PELD score to more closely predict a patient's mortality:

- **Hepatocellular Cancer (HCC)**
  A candidate with an HCC tumor that is stage T2 may be registered at a MELD/PELD score equivalent to a 15% probability of candidate death within 3 months. Certain other cancer conditions may also affect the scoring of the candidate. The largest dimension of each tumor must be reported (i.e., 1.5cm x 2.5cm must be reported as 2.5cm). Nodules <1cm are indeterminate and cannot be considered for additional priority For the purposes of this policy, stage T2 lesions are defined as
  1 lesion ≥ 2cm and ≤5cm; OR
  2 or 3 lesions, ≥1cm and ≤3cm in size.
- **Liver Candidates with Exceptional Cases**
  Special cases require prospective review by the Regional Review Board. The center will request a specific MELD/PELD score and shall submit a supporting narrative. The Regional Review Board will accept or reject the center's requested MELD/PELD score based on guidelines developed by each RRB. Centers may apply for a MELD/PELD score equivalent to a 10% increase in candidate mortality every 3 months as long as the candidate meets the original criteria. Unless the applicable RRB has a pre-existing agreement for a higher point assignment for these diagnoses, an initial MELD score of 22/ PELD score of 28 shall be assigned.

♦ **Liver Candidates with Hepatopulmonary Syndrome (HPS)**
Candidates with a clinical evidence of portal hypertension, evidence of a shunt, and a PaO2 (partial pressure of oxygen in arterial blood) < 60 mmHg on room air will be listed at a MELD score of 22 without RRB review with a 10% mortality equivalent increase in points every three months if the candidate's PaO2 stays below 60 mmHg.

♦ **Liver Candidates with Cholangiocarcinoma**
Candidates meeting the criteria will be eligible for a MELD/PELD exception with a 10% mortality equivalent increase every three months.

♦ **Liver Candidates with Cystic Fibrosis**
Liver candidates with signs of reduced pulmonary function, defined as having an FEV1 that falls below 40%, will be eligible for a MELD/PELD exception with a 10% mortality equivalent increase every three months. (FEV1 - forced expiratory volume in 1 second)

♦ **Liver Candidates with Familial Amyloid Polyneuropathy (FAP)**
Candidates with a clear diagnosis will be eligible for a MELD/PELD exception with a 10% mortality equivalent increase every three months.

♦ **Liver Candidates with Primary Hyperoxaluria**
Candidates with AGT deficiency proven by liver biopsy and listed for a combined liver-kidney transplant will be eligible for a MELD/PELD exception with a 10% mortality equivalent increase every three months.

♦ **Liver Candidates with Portopulmonary Syndrome**
Candidates that meet the criteria will be eligible for a MELD/PELD exception with a 10% mortality equivalent increase every three months.

♦ **Combined Liver-Intestine Candidates**
Candidates awaiting a combined liver-intestine transplant who are registered and active on both waiting lists will automatically receive an additional increase in their MELD/PELD score equivalent to a 10% risk of 3-month mortality. Candidates ages 0-17 will receive a 23 point increase in their calculated MELD/PELD score instead of the 10% increase.

Let's Talk Encephalopathy

If you have ever said:

"I feel like my head is in the clouds."

"I'll walk into a room and forget why I am there."

"I am always tired…but I can't sleep."

"I often forget what to say in mid-sentence."

"My boss is telling me that my work is slipping."

"My handwriting has changed to scribble."

"My hands shake so much; I can't hold my coffee cup without spilling it."

You may have experienced HE!

One of the most important jobs that our livers do is to filter toxins from our blood. When our diseased livers can no longer handle this job, symptoms of hepatic encephalopathy can occur. The basic definition of hepatic encephalopathy is confusion associated with underlying Liver disease. There are different stages of encephalopathy:

Stage 0 lack of detectable changes in personality or behavior, asterixis (hand flap) absent

Stage 1 trivial lack of awareness, shortened attention span, impaired addition or subtraction, hypersomnia, insomnia or inversion of sleep pattern, euphoria or depression, asterixis detectable

Stage 2 lethargy or apathy, disorientation, inappropriate behavior, slurred speech, obvious asterixis

Stage 3 gross disorientation, bizarre behavior, semi stupor to stupor, asterixis generally absent

Stage 4 coma

There can several causes of encephalopathy including the buildup of toxins such as but not limited to ammonia, which is due to the failing liver. Other causes are:

- infections
- kidney failure
- gastrointestinal bleeding
- dehydration (often caused by vomiting, diarrhea, inability to take proper fluids, and by diuretics used to treat ascites and edema)
- constipation
- medications (such as but not limited to morphine, Demerol, Delaudid, Hydrocodone, Xanax, Benadryl , Phenergan , some supplements)
- alcohol and illicit drugs

Toxins

During digestion, toxins that the diseased liver produces may no longer be able to clear from your body. Ammonia is only one of these toxins but is the only toxin that can be routinely measured with current testing. The assumption is that if the ammonia level is elevated so are the other toxins. Ammonia may or may not be the toxin causing encephalopathy. It may be another toxin or a combination of toxins.

Diagnosis is easy in advanced stages. The patient is often extremely sleepy, to the point where it is almost impossible to awaken them or they may even be in a coma.

Earlier stages can be harder to diagnose. Symptoms can be confused with depression, anxiety or dementia however there are important differences. Patients with depression, anxiety and dementia usually have symptoms that build up over a long period of time. Patients with encephalopathy usually have symptoms that fluctuate and may improve with treatment. Your doctor may order test such as CT scans, MRI's, EEG to look for changes and to rule out other causes. A psychiatrist may perform certain mental status test.

Your doctor may ask you to hold your arms out straight with your wrist flexed, like a traffic officer stopping traffic. This is to check for a type of flapping tremor called *Asterixis* (liver flap). He may also check your breath to see if you have *fector hepaticus* (liver breath). Both symptoms are common with encephalopathy.

Elevated ammonia levels may also be present; however diagnosis based on these levels can be unreliable. The sample must be from an arterial sample, kept cold and processed immediately. Another problem is that patients react differently to ammonia. Some patients have noticeable symptoms with low to near normal levels while others have no symptoms at higher levels. Because of all these variables, many doctors no longer run routine ammonia levels unless the patient is hospitalized with overt symptoms or coma.

The "gold standard" treatment for encephalopathy is a medication called ***lactulose*** (Enulose) a syrup or ***kristolose*** a powder that mixes with a liquid of the patient's choice. Both medications are antibiotics that pull ammonia from the body and expel it in the patients stool. Dosage is usually to drink 30ml of lactulose or one packet of kristolose several times a day. The goal is usually 2 to 4 loose stools per day. Most doctors allow patients to adjust the dosage at home to keep HE symptoms under control. Patients that are unable to drink lactulose may have a solution delivered via a nasogastric tube or by enema.

When lactulose no longer controls symptoms sufficiently, the patient's daily medications may expand to include an antibiotic. Although antibiotics are effective alone, they are usually given in addition to lactulose. Antibiotics help reduce bacteria in the intestines that can produce toxins.

neomycin has been used of years and works well, however long term use can cause hearing loss and kidney problems.

rifaximin (Xifaxan) is an antibiotic, recently branded) that works very well because it works solely in the intestines. It has fewer side effects and appears to be easier on the kidneys**.** However it is quite expensive and not all insurance will cover the cost. There are programs from the manufacturer to help patients afford this medication.

Neither antibiotic works quickly enough to be effective as the sole treatment in an emergency.

Taking daily steps to prevent flairs involves being proactive in your own health care. However because of the very nature of encephalopathy (mental confusion) this responsibility often falls on the shoulders on our caregivers.

Take your lactulose. If you are having difficulty swallowing it, mix it in a flavored beverage. Caregivers may have to hide it in foods and drinks.

- Monitor your daily BM's and symptoms
- Limit animal proteins (especially red meat— ammonia is a byproduct produced in the digestive process)

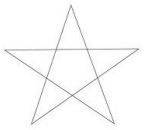
Watch for signs of gastrointestinal bleeding

Black tarry stool or vomitus

- Avoid liver toxic substances (alcohol, certain medications and some supplements)
- Monitor for infections (if symptoms increase check your temperature, always report any symptoms of an infection)
- Monitor for hydration (fluid is a delicate balance of cirrhosis patients)
- Call your doctor is your symptoms change

Mike (MikeAlpha1) has given us a real good way to test our mental faculties on a daily basis. Mike and his wife Perri started a log book that Mike completed during each day. Perri could then check the log when she returned from work or being out. In the log, Mike would enter the date, his weight, time (hour) he took his lactulose, a check mark for each BM, his signature and a 5-point star (the kind where you don't lift your pencil from the paper.

Here are Mike's instructions for drawing the star: "*Put pencil point on paper draw diagonal up to right, down to right, up to left (beyond first point), horizontal to right beyond third point and back to starting point. If you can make the star and the starting and ending points touch you're not too bad. If you can do points but ends don't necessarily meet, HE is worse watch out, up the lactulose if you can! If it's a circle ... take action.*"



Not only does this log keep track of key information that could help manage the symptoms of HE, but it accurately shows if there has been any loss of small muscle control with his signature and his ability to reason through a simple puzzle like the star. The weight entry helps track ascites.

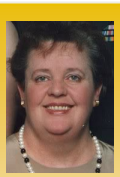
Dr. Sanjiv Chopra's Liver Book : By Sanjiv Chopra MD

The First Year Cirrhosis : By James L Dickerson

Lactulose as a life preserver : Jennifer Pate MD (Liver Health Today; Vol.11No.3)

MDJunction Cirrhosis Support Group Newsletter

Corners



Gail "mpmom"
Fatty Liver Disease

I am a wife and mother who wants people to have information available in a simple and understandable format. My quest to find information when I was first diagnosed with cirrhosis led me to create the site that is now "My Sick Liver dot com". I have had numerous health issues over the years and was finally diagnosed with cirrhosis as the result of fatty liver disease I also have diabetes and psoriatic arthritis. "My Liver may control my daily life but I am much more than my liver."

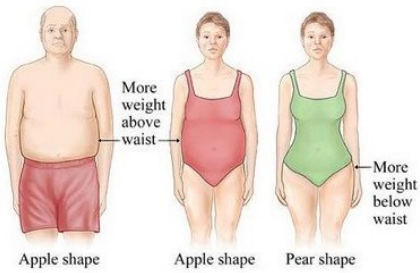
But I'm not fat!

Yes being overweight is a major risk factor for ***fatty liver*** but it's not the only risk factor.

Metabolic syndrome is a group of risk factors that increases our risk of many things like diabetes, high blood pressure, stroke, heart problems, kidney problems and yes, fatty liver. The two most common risk factors for metabolic syndrome are:

1) Extra weight around the middle and upper parts of the body (central obesity). The body may be described as "apple-shaped."

2) Insulin resistance, in which the body cannot use insulin effectively. Insulin is necessary to help control the amount of sugar in the body. As a result, blood sugar and fat levels rise. "You do not have to be diabetic to have Insulin resistance."

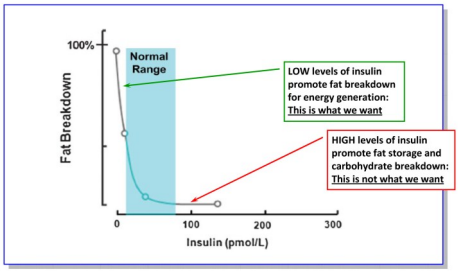


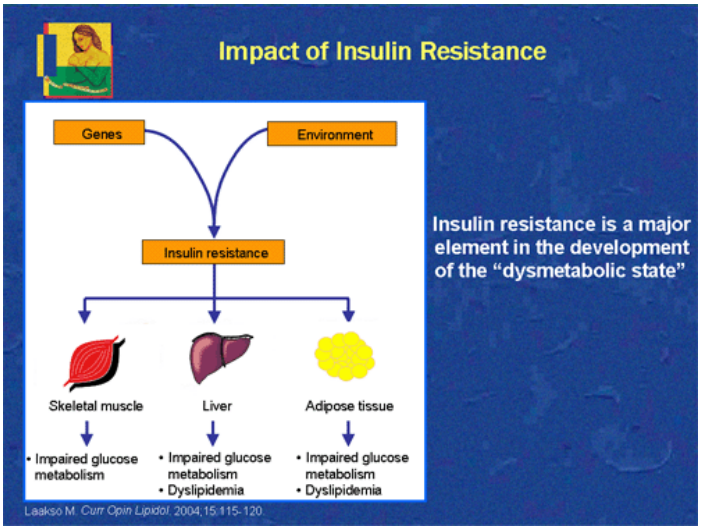
Other risk factors are:

- Aging
- Genes that make you more likely to develop this condition
- Hormone changes
- Lack of exercise
- Smoking
- High Cholesterol / Triglyceride levels

A diagnosis of metabolic syndrome requires 3 of the following conditions:

- Blood pressure equal to or higher than 130/85 mmHg
- Fasting blood sugar (glucose) equal to or higher than 100 mg/dL
- Large waist circumference (length around the waist):
  - Men - 40 inches or more
  - Women - 35 inches or more
- Low HDL cholesterol:
  - Men - under 40 mg/dL
  - Women - under 50 mg/dL
- Triglycerides equal to or higher than 150 mg/dL



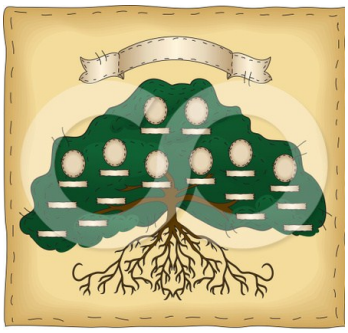


Insulin resistance alone is also a major risk factor for fatty liver. Insulin is a hormone made by your pancreas that helps control the amount of sugar in your bloodstream. Normally, your digestive system breaks down the foods you eat into glucose (sugar). Your blood carries the glucose to your body's tissues, where the cells use it as fuel. Glucose enters your cells with the help of insulin. In people with insulin resistance, cells don't respond normally to insulin, and glucose can't enter the cells as easily. As a result, glucose levels in your blood rise despite your body's attempt to control the glucose by churning out more and more insulin. The result is higher than normal levels of insulin in your blood. This can eventually lead to diabetes when your body is unable to make enough insulin to control the blood glucose within the normal range.

Even if your levels aren't high enough to be considered diabetes, an elevated glucose level can still be harmful. In fact, some doctors refer to this condition as "pre-diabetes." Increased insulin raises your triglyceride level and other blood fat levels. It also interferes with how your kidneys work, leading to higher blood pressure. These combined effects of insulin resistance put you at risk of heart disease, stroke, diabetes and fatty liver.

Family history is quickly becoming a recognized risk factor,

First: Insulin resistance, metabolic syndrome, obesity, diabetes all tend to run in families.



Second: Many of us have relatives that may have had fatty liver and never have known. Doctors did not test for fatty liver until mainly the last decade. There very well could have been several relatives with fatty liver.

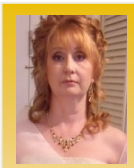
Third: Geographically we tend to eat the same types of foods as our parents. In the last 30 years fast food restaurants have increased in number considerably. But even without fast food almost all regions have their healthy and unhealthy foods. I can't begin to count the unhealthy foods we eat here in the South. Sure we eat lots of fresh veggies, but often they are fried or in a yummy casserole.

Nope, you don't have to be fat, but living healthier is the only thing we can do to delay the progression of our disease.

http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004546/

http://www.mayoclinic.com/health/metabolic%20syndrome/DS00522/DSECTION=causes

http://www.heart.org/HEARTORG/Conditions/More/MetabolicSyndrome/Metabolic-Syndrome_UCM_002080_SubHomePage.jsp



Marg "sadlystillsane"
Primary Biliary Cirrhosis

I am a wife and mother with Primary Biliary Cirrhosis. I have three kids; Kelsey is my daughter and Ryan and Linsey are my boy and girl twins. My husband Doug and I have been married since April 8, 2011. I worked with federal inmates who had been granted parole until taking disability leave in January of 2012. I live in sunny Saskatoon Saskatchewan, a beautiful city which I love. I have three great doctors and one bad liver. I have found over the last year or so that it is the little things, and the people I love that matter most, and I am not ready to let go anytime soon..... :)

No Man Is an Island

"*No man is an island, entire of itself; every man is a piece of the continent.*" is a famous quotation from John Donne. One we have all heard. But lately I have been thinking about it. About being an island. Sometimes the isolation of this illness feels like I am alone on an island. I can see and hear all kinds of people around me, but I am on my own island and they cannot or will not be able to reach me.

Part of what put me on the island was I of course. I found out how sick I was and part of me instinctively turned inward, focusing on the illness—learning about it, coping with it, thinking about the future with it. That led me to spending time on the island. Part of me also felt it would be better to stay on the island, away from others. Thought it might hurt less that way. If I isolate from them they cannot isolate from me.

Another reason I am on the island is the fact that my illness limits me so much. I no longer have the stamina to shop all day with my girlfriends, or go out for lengthy dinners and drinks with other couples. I often find myself exhausted from the process of showering and dressing to go out in the first place. I also feel pain and discomfort and find it hard to sit for prolonged periods. I usually want to lay down by 8 pm or so. That is not really conducive to much of a social life. The physical aspect of my disease puts me on the island too.

Emotionally I am firmly an island inhabitant. Some days it is all I can do to smile at my husband or have a kind word for my kids when they phone. I get wrapped up in feeling sick and being sick and thinking about the future I will have while sick. It takes a lot of emotional energy to live with this illness. Sometimes that limits what emotions I have for others in my life. Makes me prioritize who I have anything to give to and leaves me on that island again.

But I am not the only one responsible for my island dwelling. There are a whole host of people in my life who have helped move me onto this shore. I have three children, a husband, his extended family and many good friends. Sometimes I think the only person I can talk to is my psychiatrist. She isn't my friend or my family, but she will get her feet wet and wade on out to the island if I am stuck on it. My family and my friends don't seem able to swim that far.

I first noticed it sometime after telling people I was ill. Their first reaction was shock and sadness and they all clustered around me, like a human wall trying to keep the disease out. Then as time went by and I started to act sick, or talk about being sick or talk about how it felt to be sick, I started to notice that some of those people were bricks falling out of my human wall. A friend from work just stopped communicating with me once I stopped working. She has had a couple of significant losses in her life and she is scared to lose me too. So she isolates herself from me. I let her because I feel guilty that I am going to cause her pain, or have already, by being sick.

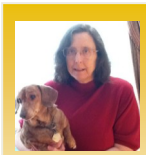
My oldest daughter has become very busy. When she was younger she was like a piece of Velcro stuck to me. As she entered her late teens and early twenties she wasn't like Velcro anymore. She became more like sticky tack. I heard from her every day, by phone or email or text or a visit. Then I got sick. Her denial of the illness was immediate. She spoke to doctors who told her many patients with PBC live for many years. She neglected to tell those doctors I was already in stage 4. Now, my little Velcro girl is so busy she doesn't have time to visit, or call or text. Getting her to commit to spending time with me is a herculean effort. She, maybe more than anyone has cast me adrift on the island I am currently living on. I try to reach out to her, to pull her close but her fear of losing her mother has all but completely isolated her from me. I worry how that will affect her once I am no longer here. What will the guilt of pushing me away now do to her then?

I think all of us feel the isolation that is the effect of the illness. Some of us may have a tiny island that is very close to shore and we can often get off the island and visit dry land. Some of us may have a larger island that is a little farther out to sea. Some of us may be on a remote island, accessible only by computer and internet. Some of us may be responsible at least in part for our island dwelling. Many of us will find that if it isn't us on the island, it suddenly seems to be much of the world around us that has moved off shore.

The computer is one tool to stave off isolation and we are lucky to be the generation that has it. No matter how ill I feel, I usually can boot up Facebook and MDJ and visit my friends there. Many of them are both places… and those are the friends that really understand what it is like to live on an island. I am so grateful for them. The computer gives me access to my work family through email and the ability to hold on to relationships that by now would have been completely lost without virtual support. My phone lets me drop a quick text to my kids, and sometimes replying to that is easier for them than a phone conversation or a visit. So I am glad my island has technology. But it is no substitute for human contact; for looking another in the eye as we share our feelings, as we laugh or cry. It is not meant to be our main source of communication. Unfortunately for many of us, it becomes just that.

So if no man is an island and many of us are on an island of our own, how do we get back to the others? Those who are not isolated by an illness that is robbing them of many of life's pleasures? I don't know the answer to that. I know we have to keep trying though. Through talking to someone who allows us to vent and say whatever we need to say so that it does not paralyze us inside; by reaching out to those who love us even when it is hard to get our heads out of our own circumstance. And maybe even by letting some of those in our lives move far away from us….for now. However we do it, we must keep the mainland in sight and keep striving to find a way back to it. While we do that we must also find a way to cope with the isolation of our illness. For most of you that are reading this, perhaps one of your best coping mechanisms is this virtual support group. It is an anchor to dry land. It lets us know what is going on out there even when we can't be there. It gives us hope. Because no man is an island.

Also reference (listen to) Simon & Garfunkel's "I am a Rock"



Susie "dachsiefan" Cryptogenic (Idiopathic) Hepatitis

I am a married woman who was first diagnosed in 1990 with giant cell hepatitis that had now evolved to cirrhosis. In 2008, I developed HE and edema. In 2011, I had the TIPS procedure to remove a portal vein clot and restore blood flow. I am currently on the UNOS waiting list for a liver.

My TIPS Experience

About two years ago, my hep doctor mentioned that the transplant committee was considering doing a TIPS procedure on my liver. I had no idea what a TIPS procedure was or why I needed one. When I got home, I went directly to the Internet and Googled TIPS procedure.

I found out that the Transjugular Intrahepatic Portosystemic Shunt or TIPS procedure involved the placement of a synthetic shunt between two of the major veins in the liver, the portal and hepatic veins. An interventional radiologist accesses the liver though the jugular vein in the patient's neck. The radiologist connects the portal and hepatic veins by placing a metallic shut with Gore-Tex covering.

TIPS procedures are commonly recommended for cirrhosis patients suffering from portal hypertension with either esophageal or gastric varices and ascites, which is a buildup of fluid in the belly. I had minor esophageal varices but never suffered a bleed. I did not have fluid buildup in my belly that required draining. I was confused. Why was my transplant team considering this procedure for me?

At my next doctor's visit, I was referred to an interventional radiologist on staff. Since he was the chief doctor of the division, I had to wait 6 weeks for my appointment. He told me that because of an old blood clot, (portal vein thrombosis), my portal vein was not receiving the blood flow from the intestinal organs that it should and was losing its viability. In order to have a successful transplant in the future, they needed to restore blood flow to the vein by removing the clot and inserting the shunt. He told me the risks of the procedure: infection, increased hepatic encephalopathy, and in some cases, death. The doctor was a very confident no-nonsense guy. I decided to proceed because for all intents and purposes, it was my best chance for a successful future transplant.

I scheduled the outpatient procedure in November 2010. I went into the procedure room at 8 AM and woke up groggily around 1 PM in the recovery area. Apparently, my veins did not match up with my prior scans that impeded them and by the time they navigated to where they needed to be, I had been under anesthesia three hours and had received the maximum amount of contrast they dared to use. Because they were concerned with the contrast's effect on my kidneys, they admitted to the hospital's observation unit for 24 hours.

The TIPS Procedure

Almost all of the complications seen in cirrhosis patients are caused by blockage in the flow of blood from the portal to the hepatic vein. The TIPS procedure bypasses this obstruction by placing stents between the two veins.

An increase in the severity of or new symptoms of encephalopathy is a very real risk of having a TIPS placement. Careful consideration of this risk is necessary before the procedure

I rescheduled the procedure for December but had to cancel due to a kidney stone hospitalization. I finally got my kidney stones and urinary tract infections under control and rescheduled the TIPS for late February 2011. I received a general anesthesia and woke up in a hospital room. The day following the procedure the interventional radiologist visited me in my room and told me that my TIPS procedure was challenging because I had developed a unique architecture of veins to compensate for the clot. They had to access then veins thru my neck and midriff area. They were able to remove most of the clot and place the stent, but he wanted to go in again in about a month to remove any residual clot. I was prescribed a clot preventing medication so that a clot would not reform around the shunt. In March I went in as an outpatient. They removed some residual clot from the portal vein, and I went home that afternoon. They scheduled me for TIPS check in July. There was no evidence of any clot, and my portal vein was good enough for eventual transplant. From here on out, I would need liver ultrasounds every six months to make sure the shunt was doing its job.

So, what were the results of my TIPS procedure? Short term, I had mild pain in my neck and midriff where they accessed my venous system—a minor inconvenience. I now have a viable portal vein for transplant surgeons to hook up to during my eventual transplant. I no longer have to take propranolol for portal hypertension, which caused low blood pressure problems and made me prone to fall (3 times in 2010). My hepatic encephalopathy has improved since the procedure. I was able to reduce my lactulose dosage from 4 tablespoons a day to two and feel more with it mentally. Occasionally, when I feel the mental fog, I just increase my lactulose dosage.

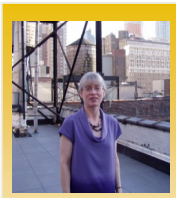
This was just my personal experience with the TIPS procedure. Others have it for different reasons and have different results. For me it was truly a bridge to transplant.

Something is different this month!

Have you figured it out yet? When we started this newsletter a couple of months ago we were focused on providing interesting information on a regular basis. We looked into various templates and tools to help with some of the more mundane aspects of making our ideas into reality. We settled on using a template from Microsoft (Publisher) that allowed for flowing text between columns and allowing those columns to be continued later in the document.

We started out with a 4-column presentation, because that is what the original template provided. Now, in retrospect, we realize that 4-columns is way too busy and very difficult to read in an online fashion. It was also difficult to insert graphics to help breakup the page or to illustrate a point in our articles.

So you'll notice in this issue that we have switched to a 2-column layout to try to resolve all the "problems" that we felt were present in our first issues. Not only do we think the new format is better looking but we also hope that you will find the new format is much easier to read, with less scrolling up and down to read through the content. You should also notice that we are trying to incorporate more graphics and pictures so that you can better interpret our articles or maybe put a smile on your face even for just a few moments.



Mo "IronCelt" Hemochromatosis

Shortly after I got married and moved across country at the age of thirty-eight, I started getting lots of weird nonspecific, invisible symptoms. When my hair starting falling out, I had something to show a doctor. I was soon diagnosed with severe hemochromatosis, at age forty, and cirrhosis six months later. I have now been dealing with these illnesses for ten years.

Encountering Bigfoot & Other Legendary Beasts

Last time I introduced my menagerie of medical professionals and likened myself to a Zebra and a Pekingese lap dog. Now my thoughts have turned to legendary beasts, examples being the ancient Mermaid, Griffin, Yeti, or the more modern *Chupacabra* and New Jersey Devil. My spouse might argue that *I'm* the New Jersey Devil, because during our semiannual trips to that state I become a roaring beast at the wheel. And I have met Bigfoot—and also discovered that it was I, yours truly.

Not long after my diagnosis of cirrhosis, my husband and I joined some acquaintances on a weekend bus trip with a baseball team's booster club. Four hours after departure, we stopped for lunch, and, like Miss Clavell in the children's story "Madeleine," I sensed that "something is not right." It seemed like my feet weren't working right. Then I looked down. My feet and ankles were puffed up like those of a giant balloon floating down Broadway in the Macy's Thanksgiving Day parade. I had become Bigfoot.

Over the next few months, on trips between my house and the medical center, my feet would start going numb within 30 minutes, before starting to swell. So I started trying the "coach class" maneuver in which you exercise each foot by rotating it one way and then the other, over and over, every few minutes.

Other ominous symptoms appeared. I'd wake in the wee hours to find that one or both legs were asleep, from hip to toe. I was like a Mermaid out of water, deposited in a bed. Sometimes I woke to find myself like Nemo the Angelfish, awkwardly trying to turn over while my left arm and leg were asleep. I also started waking up with tight, severe chest pain when I had been sleeping on my left side. I also discovered that I had distended jugular vein on the left side of my neck. I could sometimes see it pulsate, like the Alien, ready to burst forth.

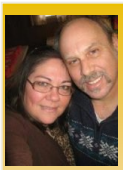
My doctor said the pain might be coming from an overloaded spleen, but since my scan reports said my spleen was fine, I came up with my own differential diagnosis: my liver was dense with swelling and scarring, so blood wasn't flowing through it very well. The chest pain suggested that, in deep sleep, my slowly beating heart was not circulating enough blood to keep the muscles oxygenated. I figured that if the liver was like a logjam on the river, I needed to increase the force of the flow: each heartbeat needed to be stronger to force the blood through the dense liver. I needed to exercise—a lot more than I had been.

The disturbed sleep might have seemed like a dream or at least a horror movie in which unseen monsters chased me through a forest while I frantically tried to figure out which way to run—or ride.

Since I can't run on my big, flat, surgically repaired feet, I got on my rickety, rusty old stationary cycle and started pedaling nearly every day. Back then I wasn't having too much fatigue, so I was able to increase the workouts up to 30 or 45 minutes. The monstrous nocturnal angina and blood-starved limb problems went away. Bigfoot vanished. But when I caught a terrible virus and secondary infections and was down and out for weeks, the nocturnal angina and numb limbs returned—then went away again once I was back on my cycling routine.

During a later cardiac workup for the hemochromatosis-induced arrhythmias, I mentioned the nocturnal angina business to the cardiologist. He scoffed at my self-diagnosis and said the tests showed nothing wrong with my heart, even though I had tried to suggest that the problem related to the liver density.

That frustrating impasse made me dream of "coordinated care," in which the medical facility coordinates all the specialists you'll need. The Mayo Clinic supposedly does this, but as far as I'm concerned, the concept is as fanciful as a herd of Unicorns with MDs.



Nina "prayer"
Steve's Caregiver

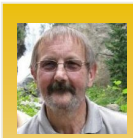
My name is Nina, I married my best friend Steve over 27 years ago, September 7th 2011 he was diagnosed with cirrhosis of the liver, caused from a genetic disorder called Alpha-1 antitrypsin deficiency, he has lost his Grandfather and his Father to this disease, our prayer is that this stops with Steve. We are blessed with one son, he and his wife have two boys. We are being carried on the wings of prayer.

Some Thing's are Worth Waiting For

A few years back an Eagle set up a nest at a nearby lake, so my husband and I decided that we would try to find it, so we went for several weekends, trudging through the woods and we finally found the nest. We had seen that a rope had been set up a good distance away from the tree so that nothing could get close enough to bother them. I am not sure how many times we went looking for an eagle to fly in or out of that nest and all we wanted was to see an eagle in its natural surroundings, we had seen them on TV and at the zoo but to see one flying in our Ohio town would have been such a treat.

After one of our weekend walks and not seeing anything we decided that it was pretty hopeless or so it seemed. The following week we went to the grocery and as we arrived home and pulled into the driveway, my husband said, "Is that an Eagle?" I could not believe my eyes! After all the walking, searching and hoping and driving the 25 minutes to get to their spot we had an Eagle flying in the field in front of our home (at the time we lived in the country), the Eagle settled in a tall tree that marked our land and I ran to get my camera from the house. We felt so blessed, what a wonderful sight and even better that we didn't have to drive and wait in the woods, the Eagle came to us! That was the one and only time that we ever saw the Eagle around our home but I will never forget it.

We can learn a lot from Eagles, when the storm comes in they will fly above the storm unless they have young then they cover them with their wings and face the storm, I am a caregiver, I am blessed to be the one that will help face this storm, even though the storms are rough, the winds almost blow me down I will stay strong and cover my husband with my wings of prayer and with all my love until he is strong enough to fly again, I miss those long walks in the woods but now we take long drives and talk about what we will do once he receives his new liver, each day is a blessing, we must take the time to smile and breath because something's are worth waiting for!



Dennis "dmanflan"
Liver Transplant Recipient

I am a father, grandfather and husband for more than 38 years who will be eternally grateful to my family for sticking with me during my dark days. I have such a spark in me to try to return as much effort that I can to support many transplant related areas as possible. I love to give my opinion on these topics!

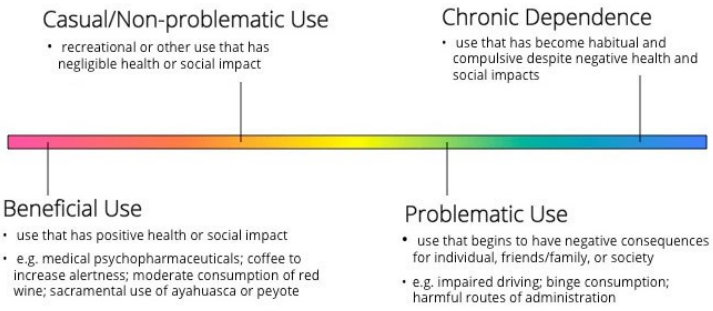
I received a new liver in July of 2008. I destroyed my native liver with alcohol developing cirrhosis with portal vein thrombosis (PVT) and eventually hepatocellular carcinoma (HCC). I had been completely sober for almost 2 years before my transplant.

What is Recovery?

Well, now that we have talked about the progression of Alcoholic Liver Disease (ALD), let's turn our attention back to the primary treatment that can be applied to slow, or even reverse, the effects of alcohol on our livers—eliminating the consumption of any alcohol from our diet. I don't want to tell you that recovery is easy or even that it is a hard process. Nor am I going to say one method of recovery is any better than another method. Let's constrain our discussion this month to what goes on during the recovery process.

So, what really is "recovery"? It depends! For the purpose of this article, I want to talk about recovery as a process—the initial steps to stopping one's abuse of alcohol. Most people who have been successful in getting past their dependence on alcohol often refer to themselves as being in recovery—according to a panel of experts *"a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship."* Journal of Substance Abuse Treatment 33 (2007) 221–228 (Betty Ford Institute) (PDF)

Most of us with ALD have had some history with not just using alcohol but abusing it. Abusing implies that *use* is in excess of amounts greater than what medical professionals approve for casual use. *Alcohol dependence* refers to continued use of alcohol despite other physical, mental or social problems associated with the use of alcohol. Withdrawal symptoms may occur after continued and repetitive alcohol abuse stops.



Treatment for alcohol dependency is critical for ALD patients. The first step towards recovery is to achieve sobriety—complete abstinence from alcohol. Unfortunately only the patient is capable of making the decision to stop drinking. If the patient does not want to stop drinking, no amount of treatment is going to help the alcoholic stop drinking. It is not a decision that can be made "overnight". In the beginning, *denial* is a major barricade. The user must first admit that they have a problem with their drinking. He/she may still find excuses to continue their destructive habit.

Like most decisions, creating a chart or list of the benefits and costs of drinking versus not drinking might provide more clarity to the user. Here is a sample list:

Benefits of drinking:
- It helps me forget about my problems
- I have fun when I drink
- It's my way of relaxing and unwinding after a stressful day

Benefits of not drinking:
- My relationships would probably improve
- I'd feel better mentally and physically
- I'd have more time and energy for the people and activities I care about

Costs of drinking:
- It has caused problems in my relationships
- I feel depressed, anxious, and ashamed of myself
- It gets in the way of my job performance and family responsibilities

Costs of not drinking:
- I'd have to find another way to deal with problems
- I'd lose my drinking buddies
- I would have to face the responsibilities I've been ignoring

My experience

I've never really dwelled on the reasons why I drank, I just did. Going back would just be too painful. I don't think it would be productive and I really can't change the circumstances anyway. Remember nobody has figured out how to time travel! That is not to say that I don't take responsibility for my actions—all I can do is apologize for any wrongs I may have committed, make a commitment to myself (most importantly) and to others to strive not take the same actions in the future and move forward.

It shames me to say that I was the prototypical alcoholic: I drank "mass quantities" alone; I drank and drove (and paid a huge price for it!); I lied about my drinking; I assumed nobody else knew I had a drinking problem; I even drank for a while after being told I had End-Stage Liver Disease (I never put it together that ELD meant cirrhosis). I tried and tried to get sober through Alcoholics Anonymous, but I just could not wrap my head around the fundamental principles of the program. I am not saying, in any way, that AA is not a good program!!! It works for many, many people but just didn't work for me.

In addition to AA I was a regular client with an AODA (Alcohol and Other Drugs of Addiction) counselor. "Fred" was most patient with me, pointing out that I was "thinking too much about it". I really learned a lot from Fred and have been using this new knowledge often, even today. I readily admit (now) that I was still using throughout both my attempt at AA and counseling. Fred and I met in both individual and group sessions. In some of our discussions we touched upon the fact that AA wasn't the only program to aid in the effort to get sober. We talked about a "28-day" program, Rational Recovery® and SMART Recovery® but I was too blind (read as "stupid"!) to even recognize that any of these programs would provide an answer to my problem.

I eventually agreed to try a 28-day program at a facility (Nova) that Fred highly recommended. I still remember that I was in between a rare hangover and withdrawal when I first arrived at Nova. It was like going to jail—my belongings were thoroughly search and I received a thorough pat down search (at least it wasn't a full strip search!). I had the rest of that day and the all of the next to complete the worst of my withdrawal and then jumped into the program.

As is clearly noted on Nova's website (which didn't exist when I "attended" [was committed]), *"For almost three decades, Nova has been grounded in the 12 Steps of Alcoholics Anonymous philosophy and believes it is the surest way to recover from the disease of addiction. Education about the illness, knowledge of the 12 Steps, and caring feedback are the cornerstones for change."* I really tried again to "get with the [AA] program". I suppressed my own beliefs and accepted the 12 Steps, at least for the duration of the program. I felt pretty good by then end of my commitment.

I guess my "thinking about it too much" eventually got the better of me! I got to thinking about my beliefs in science and evolution in comparison to AA's "higher power" concept. I found myself in a quandary about the rest of the AA program. My condition was tenuous at best! I was soon drinking again.

During all these attempts at getting sober my family life, financial situation and social network was deeply impacted. Once these situations started to deteriorate to a certain level, I really thought about what ***I*** *was* doing and what I *should be* doing. I suddenly seemed that I was going to lose everything. I will always remember a very firm lecture from my oldest son that I needed to do something. *I did! I got serious about getting sober so that I could get my life back!*

Next month we'll talk about my experiences with Rational Recovery® and SMART Recovery®. We'll also get into the physical, mental and life style changes that can be expected on the path to sobriety.

Tips & Tricks

While looking for a recipe for this month's newsletter, we came across some great dietary tips that Bobbi posted back in March, 2011. These are in our Liver Friendly Recipes and Diet Tips Forum.

"Here's a synopsis of the notes on my fridge regarding low sodium eating. You must always consider your individual health needs, (i.e., diabetes, allergies, etc.) when making your selections. I personally limit fats to a minimum and eliminate processed sugars. "

Bread: Low sodium = 5 mg/slice Regular = 120 mg/
Use: Two slices regular or 4 slices low sodium bread, rolls, crackers. Limit bread with baking powder to one slice/day
Avoid: Regular bread except in amount allowed. Crackers, commercial mixes, self-rising corn meal or flour, chips, pretzels, other similar snack items

Cereal: 5 mg sodium per 1/2 cup cooked or 3/4 cup dry
Use: Puffed rice/wheat, shredded wheat, regular oatmeal, cream of wheat, malt-o-meal, rice, grits
Avoid: Quick cooking cereals, instant hot cereals

Fruits: 2 mg sodium per 1/2 cup
Allowance: 3+ servings/day
Use: Any kind — fresh, frozen, or canned
Avoid: Maraschino cherries, dried fruit, crystallized or glazed fruit

Vegetables: 9-25 mg sodium per 1/2 cup
Allowance: 2+ servings/day (1 serving = 1/2 cup cooked or 1 cup raw) Potato/ Potato Substitute (5mg sodium per 1/2 cup)
Use: All fresh/frozen, except those listed under avoid. Low sodium tomato juice or V-8 juice White/sweet potatoes, macaroni, noodles, rice, dried beans
Avoid: Canned vegetables or juice with salt added. Sauerkraut, frozen lima beans or peas. Potatoes processed with salt, including canned, dried, frozen, or instant.

Meat, Fish Poultry: (25 mg sodium per ounce)
Allowance: 2 servings/day (1 serving = 2-3 ounces)
Use: Fresh, frozen, canned without salt. Beef, pork, veal, lamb, chicken, turkey, duck, rabbit, fish (rinsed), low sodium tuna/peanut butter
Avoid: Brains, kidney, canned, salted, or smoked meats, bacon, bologna, corned beef, frankfurters, ham, lunch meats, salt pork and sausage, peanut butter

Egg: (60 mg sodium each)
Allowance: Consult your doctor or dietitian
Use: Any style
Avoid: Eggs prepared with ingredients not allowed, pickled eggs

Cheese: Check labels and Consult doctor or dietitian
Use: Dry curd cottage cheese, low-sodium cheese, ricotta cheese
Avoid: All other cheeses and processed varieties

Milk: 1 serving = (120 mg sodium/ 8 ounces)
Allowance: 2 cups/day
Use: Low fat, whole, skim, homemade uncultured buttermilk, yogurt
Avoid: Cultured buttermilk

Fats:
Allowance: Consult your doctor or dietician
Use: Unsalted butter/margarine/fat/oil, unsalted salad dressing or mayonnaise, unsalted nuts
Avoid: Regular butter/margarine, commercial salad dressings or mayonnaise, bacon, bacon fat, olives, pickles, salted nuts, spreads, dips

Desserts: Allowance: 1 serving/day
Use: Sherbet, popsicles; fruit pie and cobbler made without salt; ice cream/ pudding can be used as part of milk allowance
Avoid: All instant puddings

Sweets:
Use: Sugar, honey, syrup, jelly, jam
Avoid: Any made with salt or other sodium compounds

Miscellaneous:
Use: Coffee, tea, lemons, limes, plain unflavored gelatin, vinegar, yeast, pepper, herbs, spices, and flavorings
Avoid: Instant cocoa mixes, beverage mixes, Gatorade, bouillon, baking powder, baking soda, rennet tablets, molasses, canned soup, commercial marinade, soy sauce, meat tenderizers, sea salt, rock salt

Recipe Corner

This substantial salad offers a healthy balance of vegetables and protein. It provides a wide range of textures, colors and seasonings.

From the American Institute for Cancer Research via SparkRecipes®.com. The American Institute for Cancer Research (AICR) is the cancer charity that fosters research on diet and cancer and educates the public about the results.

Ingredients

1 ½ cups	quinoa
1 ½ cups	canned black beans, rinsed & drained
1 ½ Tbsp	red wine vinegar
1 ½ cups	cooked corn (fresh, canned or frozen)
1	red bell pepper, seeded & chopped
4	scallions, chopped
1 tsp	garlic, minced fine
¼ tsp	cayenne pepper
¼ cup	fresh coriander leaves, chopped fine
1/3 cup	fresh lime juice
½ tsp	salt
1 ¼ tsp	ground cumin
1/3 cup	olive oil

Directions

1. Rinse quinoa in a fine sieve under cold running water until water runs clear. Put quinoa in a pot with 2 ¼ cups water. Bring to a boil, then cover and simmer 20 minutes or until water is absorbed and quinoa is tender. Fluff quinoa with a fork and transfer to a large bowl and allow to cool.
2. While quinoa is cooking, in a small bowl toss beans with vinegar and salt and pepper to taste.
3. Add beans, corn, bell pepper, scallions, garlic, cayenne and coriander to the quinoa. Toss well.
4. In a small bowl whisk together lime juice, salt, cumin and add oil in a stream while whisking. Drizzle over salad and toss well with salt and pepper.

Salad may be made a day ahead and refrigerated, covered. Bring to room temperature before serving.

Makes 8 servings.

Nutrition Facts

Serving Size: 1 serving

Amount Per Serving	
Calories	**370.7**
Total Fat	**13.2 g**
Saturated Fat	1.3 g
Polyunsaturated Fat	1.0 g
Monounsaturated Fat	6.5 g
Cholesterol	0.0 mg
Sodium	**210.3 mg**
Potassium	**257.0 mg**
Total Carbohydrate	**55.1 g**
Dietary Fiber	**8.0 g**
Sugars	2.5 g
Protein	**10.6 g**
Vitamin A	6.5 %
Vitamin B-12	0.0 %
Vitamin B-6	5.9 %
Vitamin C	49.4 %
Vitamin D	0.0 %
Vitamin E	7.5 %
Calcium	2.3 %
Copper	5.4 %
Folate	18.3 %
Iron	8.2 %
Magnesium	8.9 %
Manganese	12.9 %
Niacin	4.2 %
Pantothenic Acid	4.1 %
Phosphorus	8.0 %
Riboflavin	4.3 %
Selenium	1.1 %
Thiamin	7.4 %
Zinc	4.2 %

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

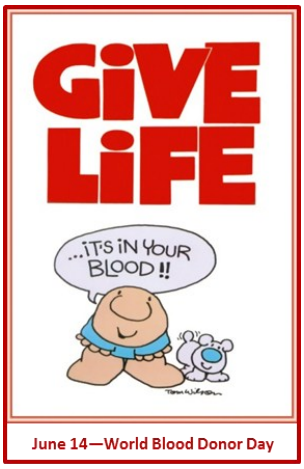
Events this Month

June 6, 1944

June 10 - National Children's Day

June 14—Flag Day

June 17—Father's Day



June 14—World Blood Donor Day

Tidbits & Quotes for the Month:

- "The free men of the world are marching together to victory"—General Dwight D. Eisenhower
- If we are to teach real peace in this world, and if we are to carry on a real war against war, we shall have to begin with the children.—Mahatma Gandhi
- "We take the stars from heaven, the red from our mother country, separating it by white stripes, thus showing that we have separated from her, and the white stripes shall go down to posterity, representing our liberty."—Flag Day Quotes attributed to George Washington,
- The only gift is a portion of thyself. ~Ralph Waldo Emerson
- In 1966 President Lyndon Johnson signed a presidential proclamation declaring the 3rd Sunday of June to be the Father's Day.
- "A truly rich man is one whose children run into his arms when his hands are empty." Author: Unknown
- A perfect summer day is when the sun is shining, the breeze is blowing, the birds are singing, and the lawn mower is broken. ~James Dent

Please let us know if there is a date that we should be commemorating or celebrating so we can add it to our calendar.

☺ None reported

Transplant Anniversaries

🎗 None reported

UNOS Waiting List
Livers (May 17, 2012)

Status 1A	2
Status 1B	12
Status 7 (Inactive)	3,203
MELD / PELD <10	4,833
MELD / PELD 11-18	5,249
MELD / PELD 19-24	1,644
MELD / PELD 25+	1,262
Total Waiting	**16,095**

Courtesy OPTN reports

YTD as of Feb 29, 2012
1,005 liver transplants performed
1,115 livers donated/recovered

- 6/3 Mareli's Dad
- 6/13 Capedrifter's wife Fumie (Momma Cape)
- Lvemkisa's stepsister