

IVUN News

A Family Home, Not a Nursing Home

Kristin Hilfiker

As a foster mother to three children with trachs, two of whom use ventilators, I know we must sound like we live in a nursing home, but it is a real home and a real family. We live in Portland, Oregon, and go camping and swimming and enjoy life. Tracy is almost 17 years old; he has muscular dystrophy; it was his decision to have a trach. Molly Ruth is almost 7 and has CCHS. She is a walking dynamo.

Tracy desaturates at night sometimes and says he doesn't breathe as well lying in bed, especially if he has a cold. He is suctioned as needed every two to six hours. Molly only needs suctioning twice a day. We change the trachs every



Tracy enjoying amusement ride

two weeks, using Bivonas which can be sterilized and reused. Molly can do her own trach changes and thinks it is funny to take it out, leave it hooked to her ventilator, and go out to play.

I am also a pediatric and NICU nurse so I understand both home care and hospital care. For help in the home, I am allowed (by the

state of Oregon) a certain number of hours of nursing care per day for each child who qualifies as medically fragile, but the agencies are expensive so there is less nursing for the dollar. (I now am allowed 12 hours per day which I can save and use in case I need extra hours.) I have found that many of the nurses I hired did not have the skills or the philosophy to care for these children. One nurse slept so soundly one night that Molly got up, took out her trach, made her ventilator alarm, and had me take care of everything before the nurse even woke up.

Currently, I use nurses and aides I hire myself and train to do things exactly my way. When I am not at home, I have nurses. When I am at home, I use aides, often my other children or young adults in nursing school whom I have known for years. I have lists of parameters that they must meet. I have an aide on duty and awake during the night. If the children are sick, I have two aides on duty. What I really have done is absorb the aides into the family.

Sometimes I think that the people who care for our children do not realize that what seem like extraordinary measures are really comforting bedtime rituals. Our bedtime ritual is Mommy doing the ETCO₂, blood pressure, medications, suctioning, taping on the oximeter, having milk, and reading a Bible story. We do that at home and when we are in the hospital.

For the times when Molly must go to the hospital, I put together a



Molly celebrating Halloween 1998

book about Molly's care: what I do and what the other caregivers do. I explain it all to the hospital's pediatric ICU staff. On admission, I explain that our goal is to return home as soon as possible, but while we are in the hospital we want to make it seem like being home. I try not to step on toes, but I am Molly's only advocate. I feel strongly about parents caring for their children. It takes a team and, as parents, we are the team leaders – everyone else is there to support us.

A power outage last year forced us to become better prepared, and we have a generator and two backup marine batteries. I also bought an inverter that plugs into the car's cigarette lighter with an extension cord that I can use with the ventilator until the generator gets going. Our power company does not have a priority list for medical emergencies so we are on our own. ■

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At publication, the Hilfikers had recently returned from Los Angeles where Molly started phrenic nerve pacing. She is now up to two hours per day with the pacers and is gradually becoming more accustomed to being without her ventilator.

Orlando Report

Judith R. Fischer

More than 450 people, including ventilator users, attended the 7th International Conference "Noninvasive Ventilation: Across the Spectrum from Critical Care to Home Care" in Orlando, co-chaired by Barry Make, MD, and Dominique Robert, MD.

The ventilator users' forum brought many queries to the representatives of the ventilator equipment and mask manufacturers (Mallinckrodt and Respironics were present) and identified solvable problems, such as improving communication and response time between the field offices and the consumers. Barbara Rogers discussed Breethezy, her project to help respiratory health professionals understand the unique needs of ventilator users. Valerie Brew-Parrish attended as the first recipient of the Margaret Pfrommer Memorial Scholarship.

Audrey King, keynote speaker in absentia, sent a video discussing why she illustrated the title of the conference so aptly. A case of pneumonia caused King, a respiratory polio survivor who frog breathes and uses nocturnal ventilation, to undergo a tracheotomy in December. She has since returned to her Toronto home and manages from 4-6 hours free

Susan Sortor Leger, RRT



of the ventilator. King addressed many issues from her unique "patient" perspective that the respiratory health professionals needed to hear.

Joseph Kaufert, PhD, from the University of Manitoba and an old friend of Canadian ventilator users, moderated a panel on psychosocial aspects of long-term ventilation. Ventilator user Alan Fiala, PhD, shared the podium with Patrick Leger, MD, to discuss nocturnal hypoventilation. As a caregiver for her husband who had ALS, Kris Charlton emphasized quality of life. Tedde Scharf captivated the plenary session "Is ventilation in the home via tracheostomy obsolete?" with her description of how she switched from tracheostomy positive pressure to noninvasive positive pressure ventilation (NPPV).

The frog breathing session with Augusta Alba, MD, and two veteran frog breathers, Gary McPherson and Steve McPherson (no relation) from Canada, who helped Dr. Alba demonstrate the technique, was packed. Susan Sortor Leger's mask workshops,

especially the custom mask-making demonstration, were equally well-attended. Mary Vanderlaan, PhD, President of the CCHS Family Network, discussed pediatric ventilator use in a session with Moises Simpser, MD, of Miami Children's Hospital.

Other sessions and workshops highlighted topics such as initiating NPPV in the home, NPPV in children, management of people with ALS, NPPV in critically ill adults, how early to begin NPPV, sleep-disordered breathing, and whether NPPV is beneficial in people with COPD.



Tedde Scharf and Judith Fischer

The presence of ventilator users during the medical sessions was noted as a definite plus by the health professionals. Our appreciation for IVUN's participation is extended to Allen Goldberg, MD, President of the American College of Chest Physicians, Dr. Make, Tony Oppenheimer, MD, and Sam Giordano, MBA, RRT, Executive Director of the American Association for Respiratory Care. ■

Audiotapes and a list of the sessions are available from CME Unlimited, (800-776-5454; cmeu@landesslezak.com).



**(L-R)
Tony Oppenheimer, MD,
Kris Charlton,
Nick Hill, MD,
and Alan Fiala.**

Nevada's Attendant Care Problems

Paula Howaniec

In 1988, I moved from California to Nevada. Coming from a state that had a good support network and active participation by the disabled, and as a ventilator user, I was dismayed to find that Nevada was far behind the times with little support. State-funded programs for the severely disabled were non-existent.

Nevada took a giant leap in 1991 when the state implemented the Disabled Waiver program. This home- and community-based waiver program funded through Medicaid for people 18-65 years of age keeps people at home by providing for skilled nursing services in the home.

Although there is a great need for such a program, the program falls short in providing the disabled an independent lifestyle. The maximum number of hours a ventilator-dependent quad can receive is 47 hours per week. Some ventilator-dependent quads in Nevada are getting as little as eight hours per week of home care. The rest of the care is left up to families.

Assisted living for the disabled began in Nevada three years ago with apartment complexes staffed with 24-hour attendants on call. Those of us who are ventilator users are shut out from this type of living situation because attendants cannot perform medically skilled services, such as suctioning, trach care, etc. In a similar vein, a new state program began in 1998 that does allow skilled services to be performed by an attendant, but the tasks must be considered "simple to perform."

Nevada spends \$30,000 per year for a senior to remain in a nursing home, but is unwilling to spend \$3,800 per year to help a senior stay at home. In 1996-1997, the state spent \$9 million on home- and community-based services compared with \$68 million for nursing home care. ■

Excerpted with permission from *New Horizons* published by Paula Howaniec. *New Horizons* will soon be available online. Contact Paula at PaulaMH@aol.com.

Muscular Dystrophy

The Parent Project for Muscular Dystrophy Research, Inc., is dedicated to finding a treatment and cure for Duchenne muscular dystrophy (DMD) and Becker muscular dystrophy, a milder form of DMD. Started in 1995 by Patricia Furlong, who has since lost two sons to DMD, the Parent Project is holding its annual two-day conference June 25-26 at UCLA. The first day features genetic research reports and progress; the second day focuses on caring and coping workshops including respiratory management, nutrition, etc. The respiratory session from the 1998 conference with John Bach, MD, Patrick Leger, MD, and Susan Sortor Leger, RRT, can be viewed on the Web site: www.parentdmd.org.

The Parent Project sponsors research at the University of Pittsburgh, UCLA, the Center for Genetic Research at the Children's National Medical Center in Washington, DC, and is affiliated with Stanford, SUNY, and the University of Missouri. Beth Israel Medical Center in New York City recently opened the Duchenne Evaluation Center at the Hyman-Newman Institute for Neurology and Neurosurgery.

The **Muscular Dystrophy Association (MDA)** is producing two 30-minute videos for release in fall 1999. Discussing respiratory problems associated with muscular dystrophy and management strategies, "Breath of Life" is for health professionals; "Breathe Easy" is for individuals with muscular dystrophy and their families. These will be made available to all the MDA clinics. Contact Steve Allen, Associate Director, Television Products Division, MDA, 3300 East Sunrise Drive, Tucson, AZ (Arizona) 85718 (800-572-1717, www.mdausa.org). ■

International Ventilator Users Network (IVUN)

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Adolf and his wife, Doro

Adolf Ratzka Honored

TIME magazine, in a special Winter 98/99 edition entitled "Visions of Europe," presented visionaries in political, social, and economic experiments who will shape Europe in the 21st century. Among those selected was Adolf Ratzka, PhD, respiratory polio survivor and ventilator user. Dr. Ratzka is one of the leaders of the European disability rights and independent living movements. He is director of the Institute on Independent Living in Stockholm, Sweden.

Disabled by polio in 1961, German-born Dr. Ratzka won a scholarship to study in the United States. In Berkeley, he met Ed Roberts and other founders of the American independent living movement. He moved to Sweden in 1973 and founded an independent living center in Stockholm, which now employs 1,300 personal assistants who are hired and trained by the individuals with disabilities who use them. Ratzka has since co-founded the European Network for Independent Living (www.independentliving.org).

Dr. Ratzka says, "With the article, *TIME* recognizes disability as a profoundly political issue in contrast to the still prevailing view of disabled people as objects of care, pity, and humanitarian concerns. I am convinced that now, at the turn of the millenium, disabled people are at the threshold of a

worldwide recognition of their human and civil rights."

Of his ventilator use, Ratzka reports, "After the acute phase of polio when I was in an iron lung, I used a cuirass and rocking bed in the '60s and '70s. Since May 1983, I have used intermittent positive pressure ventilation only, via nose. First, I used homemade devices, but in 1985 I received a small grant that enabled a German friend, a physicist and great tinkerer, to work with me on a nasal mask for nocturnal use. The next year I found a Swedish dental technician, Lennart Remmer, who became interested and who has since made other custom nasal masks secured by head straps. I asked him to link the nasal mask to a dental piece that is secured to the upper teeth, fastening it there instead of using head straps. I get a rather good fit, handsome looks, and very little air leakage. However, after some months, the dental piece loses some of its tight fit, and I must use 3M's special skin tape for fastening the nasal mask to my nose. In this way I use nasal masks for several years in a row until they become too worn out or accidentally dropped and broken beyond repair.

"During the day, I use mouth intermittent positive pressure via a simple tube (internal diameter about 5 mm, altogether about 6 mm thick), without any mouth-piece whatsoever and without any of those ICU-looking coils. I get my tubing from the hospital. Before, I bought it at the gas station around the corner until somebody pointed out that the material might not be good for my health. I simply hold the hose in my mouth with my teeth. When the end of the plastic hose gets badly chewed up after a month or so, I pull out my pocket knife and cut off half an inch. (I love to do this

in public to de-mystify ventilators in peoples' minds!) The translucent hose is quite an elegant solution, comparable to sucking on a long pipe. Sometimes in a heated argument I use the hose to underline a point.

"I use the Eole 3 ventilator from the French manufacturer Saime, S.A. I did not choose the Swedish-made Breas because its soft bellows did not allow me to "save" three to four breaths for a vigorous cough. Before the Eole, I used the PLV-100, which is a very robust and reliable machine that I have had for over 15 years. The Eole is lighter, only 8 kg and draws, with my air requirements, only about 12W. Its internal battery is good for about five hours. When I fly, I carry a battery (18 amps) in the Eole's practical handbag and have over 20 hours of breathing time without ever needing to use the aircraft's power.

"Since December 1998, I have had two Eole machines, one for daytime and the other for nocturnal use, and they seem reliable, too. The Eole is a bit smaller than the PLV-100, and it is easier to mount under the seat of my electric wheelchair, the Quickie Pro 300 (1993 model). I modified the wheelchair, using smaller batteries among other things, in order to accommodate the ventilator under the seat. The Quickie has large rear wheels. Unfortunately, most wheelchair makers now sell power chairs with small rear wheels and use up all the space under the seat for batteries, motors, and electronics, leaving very little space for something as large as a ventilator." ■

ADDRESS: Adolf Ratzka, PhD, Institute on Independent Living, Petersens Vag 2, 127 41 Stockholm, Skarholmen, Sweden (+46-8-740 42 00; +46-8-740 45 00 fax; ratzka@independentliving.org).

New Equipment

The **LTV1000™** from Pulmonetic Systems, now approved for home care, is a completely new ventilator, weighing 12.6 lbs. and using turbine-driven, compressorless technology. There is an internal battery, cigarette lighter adapter, and comprehensive alarms. Contact David Fowler, Pulmonetic Systems, 930 South Mount Vernon Avenue, Suite 100, Colton, CA (California) 92324 (800-754-1914; www.pulmonetic.com).

TBird® Legacy from Bird Products is a pressure support ventilator for home care, also turbine-driven and compressorless. Bird is now part of Thermo Electron's Thermo Respiratory Alternate Care (TRAC) group. Contact Christian Cordero, TRAC, 1100 Bird Center Drive, Palm Springs, CA (California) 92262 (877-874-8722; www.thermoresp.com).

Uni-Vent™ Eagle™ 754 is a new volume ventilator with a self-contained compressor-blender, weighing 13 lbs. with internal backup, alarms, and AC/DC rechargeable battery. Contact Tony Altamore, Impact Instrumentation, Inc., 27 Fairfield Place, West Caldwell, NJ (New Jersey) 07006 (973-882-1212; www.impactinstrumentation.com).

Breas® Medical, a Swedish manufacturer of home ventilators, has applied for FDA clearance to sell its equipment in the USA. Breas offers the PV 100 CPAP, PV 101 and PV 102 bi-level pressure machines, PV 401 pressure support ventilator, and PV 501 volume ventilator. Contact Downey Wright, RRT, European Sales Manager, Breas Medical, 3 Blenheim Close, Wilmslow, Cheshire SK9 2DN, England (+44-(0)-1625-540449, dwright@breas.u-net.com). Head office address is Göte-

borgsvägen 91B, SE-431 37 Mölndal, Sweden (www.breas.se).

AIROX Home 2 is a new, small portable volume ventilator with alarms and rechargeable battery from a French manufacturer, BiOMS. It is not available in the USA. Contact BiOMS, Parc d'activités Pau-Pyrénées, L'échangeur, B.P. 833, F-64008 PAU, Cedex, France (+33 (0) 5 59. 92.36.66, +33 (0) 5 59.02.26.88 fax).

New Masks

The Profile™ Custom Nasal Mask from Respironics has a new inner seal that molds to facial contours and can be reformed. The inner layer creates the seal so that the head straps do not have to be pulled as tight to reduce leaks. The mask is boiled for four minutes, cooled for 10 seconds in cold water, and then pressed against the face. The process can be repeated if the mask needs to be refitted. A doctor's prescription is necessary. Contact Respironics (800-669-9234, www.respironics.com).

Alan Fiala, who uses nocturnal ventilation, reports on his trial with the Profile™ which he tested during the noninvasive ventilation conference in Orlando: "The mask was fitted while I was seated in an upright position, not the recommended procedure, because I was warned it should have been fitted while lying down. It worked wonderfully the first two nights in Orlando, then developed leaks when I got home. Over the next two weeks, I also developed a very bad abrasion on the bridge of my nose. I re-boiled the mask to fit while I was in my normal sleeping position and reduced the spacer. The abrasion went away and leakage was reduced

though not eliminated. It is still better than the Gold Seal mask. I thought the moisture from my humidifier might be part of the problem, but turning it off a couple of nights did not help. End result is that the mask is working satisfactorily now."

Breathing Technologies Corp. presents the **Nasal-Aire**, a nasal mask with soft silicone nasal inserts. It is designed to be worn like an oxygen cannula and does not use headgear. FDA clearance for home care use is pending. Contact Tom Woods, Breathing Technologies Corporation, 1909 Tebeau Street, Waycross, GA (Georgia) 31501 (888-419-0576).

SleepNet offers two new headgear styles for its **Phantom®** nasal mask. One is a comfort cap; the other is strap headgear. Contact SleepNet Corporation (800-222-3727, www.sleep-net.com).

Older Equipment

As an alternative to nasal/face masks, the **Bennett lipseal** is still available from Mallinckrodt, but only to home health care dealers, not individuals. The lipseal is called the Bennett Seal Mouthpiece Assembly (#4-000730-00). Contact Mallinckrodt (800-635-5267).

The **pneumobelt** is also still available, but on a rental basis through Respironics and called an **exsufflation belt**. It is available in small (#11030), medium (#11020), and large (#11010) sizes. To locate a Respironics Customer Satisfaction Center near you, call 800-669-9234 or consult the *IVUN Resource Directory 1998-1999*, page 13. ■

The Choice of Interface: Can It Make a Difference?

Susan Sortor Leger, RRT

Adapted from a talk presented during the 7th International Conference, "Noninvasive Ventilation: Across the Spectrum from Critical Care to Home Care," Orlando, Florida, March 14-17, 1999

Noninvasive positive pressure ventilation (NPPV) is a safe and effective means of improving gas exchange in individuals with many types of respiratory failure. When initiating NPPV, a great deal of focus is usually placed on the selection of appropriate candidates for NPPV and the ventilator to be used, but the choice of interface is often a secondary consideration. Thus, it is not surprising that failure in using NPPV is due to problems with the interface.

Inability to tolerate the mask is a major limitation to the success of NPPV. Tolerance of the mask and delivery of airflow can limit the initial settings, primarily the rate at which pressure increase can be achieved. In acute respiratory insufficiency, getting the individual comfortable and settled with the technique as quickly as possible is critical because the initial response to NPPV is an important predictor of successful therapy.

There is a wide range of commercially available interfaces in various styles and sizes, enabling an acceptable seal and fit in the vast majority of ventilator users. Yet there is no single mask that will match the needs of all individuals, and therefore clinicians need to be willing to try a number of styles and develop novel approaches to find the best fit.

Factors which can influence the choice of interface include: acute vs. chronic condition; mode of ventilation; type of ventilatory system and ability to compensate/tolerate leaks; nasal patency; ability to maintain mouth closure; length of time NPPV used; and expertise, experience, and resources of local respiratory health professionals. ■

Interface	Advantages	Disadvantages
Nasal mask	Natural humidification Wider range of types and sizes Individual able to speak, expectorate	Skin breakdown on bridge of nose Leaks, especially from mouth Eye problems
Nasal mask with chin strap	Better control of mouth leaks	Potential discomfort Difficulty expectorating, eating, swallowing
Low profile	Avoids skin breakdown Avoids claustrophobia	Allergic reaction to silicone
Face mask	Allows nasal or oral breathing Better control of mouth leaks	Claustrophobia Air swallowing Difficulty expectorating, eating, swallowing
Mouthpiece	Alternative for day-time use Alternative to nasal NPPV	Hypersalivation, nasal leaks, oral dryness, dental problems
Mouthseal assembly	Alternative to nasal PPV	Dental problems

Problem	Causes	Consequences	Solutions
Air leaks >20LPM around mask (6-20LPM normal)	Poor-fitting mask	Individual/ventilator dysynchrony Loss of delivered press./vol. Discomfort, conjunctivitis	Use leak-tolerant ventilator Re-size mask Use comfort flap
Oral leaks	Raised upper airway pressure Loss of tone in soft palate, buccal muscles High inspiratory flows/pressure	Loss of delivered press/vol. Discomfort Individual/ventilator dysynchrony	Increase PEEP Use chin strap or full face mask Decrease inspiratory flow, inspiratory rise time, or decrease delivered pressure
Skin irritation	Mask too tight Poor skin condition	Discomfort Skin breakdown Pressure sores	Verify mask fit Use comfort flap Wound dressing Alternate interfaces Decrease strapping pressure
Mask intolerance	Mask too tight Claustrophobia Inappropriate interface	Failure to tolerate NPPV	Try variety of interfaces Coach/reassure individual
Allergic reaction	Manufacturer's surface coating Mask material – vinyl, silicone, polyurethane	Failure to tolerate NPPV Discomfort Skin breakdown	Soak mask in warm water for several hours Identify early Change mask material
Nasal dryness	High inspiratory flow Dehydration	Increased airway resistance Discomfort Decreased NPPV effectiveness	Add humidification
Oral dryness	Oral leaks	Discomfort Decreased NPPV effectiveness	Chin strap, full face mask, Add humidification

ADDRESS: Susan Sortor Leger, RRT, Training and Medical Education Specialist, Respironics Europe, 76 rue de Billancourt, Apt. C303, F-92100 Boulogne, France (susanleger.sortor@respironics.com).

Noninvasive Positive Pressure Ventilation (NPPV) for People with COPD: A New Group of Ventilator Users?

Chronic obstructive pulmonary disease (COPD) refers primarily to diseases characterized by airflow obstruction and airway inflammation, such as emphysema, bronchitis, and asthma. COPD differs from neuromuscular diseases and restrictive lung conditions, such as muscular dystrophy, ALS, post-polio, or scoliosis, in which the lungs are sound, but the problems are usually ones of respiratory and diaphragmatic muscle weakness, and chest wall stiffness.

Hypoventilation and hypercapnia may occur in people with either COPD or restrictive disorders. Assisted ventilation is generally used to manage this in people with neuromuscular and restrictive lung conditions. People with COPD who have hypoxemia are usually managed with long-term oxygen therapy, but now, some physicians are using nocturnal NPPV in combination with oxygen for people with COPD who are hypercapnic.

Pulmonologists are conducting studies to determine just how beneficial NPPV is for certain subsets

of people with COPD, especially those with acute exacerbations or chronic hypercapnia. The point at which treatment with NPPV should be initiated in people with COPD has not been determined. Small studies have shown that NPPV is sometimes beneficial in selected people with stable COPD.

Many studies demonstrate that when acute respiratory failure occurs in people with COPD requiring hospitalization, about 60% can be successfully treated with NPPV, thereby avoiding intubation. The randomized studies of nasal ventilation with BiPAP® systems reported that compliance was a problem: often people with COPD do not tolerate NPPV with a nasal mask or pillows. Poor compliance may be a reason why long-term NPPV is unsuccessful.

The questions for IVUN are: Just who is a "ventilator user?" Should people with COPD who use NPPV be considered "ventilator users?" Do they face the same issues that people with neuromuscular disease face? Would ventilator users with

neuromuscular disease benefit by networking with people with COPD and vice versa? Will this group enlarge the population of ventilator users and produce a larger "consumer" group with more clout? Anyone who wishes to respond should contact IVUN, 4207 Lindell Boulevard, #110, Saint Louis, MO (Missouri) 63108-2915 USA (314-534-5070 fax; gini_intl@msn.com). ■

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Potpourri

Glossopharyngeal ("frog") Breathing - what, when, and how? Is teaching frog breathing a dying art? An educational 43-minute video for physiotherapists, other health care professionals, and patients on how and when to teach/learn this technique. Produced by Barbara Webber, FCSP, former head of physiotherapy at Royal Brompton Hospital in London, and Jane Higgins, MCSP, former head of physiotherapy, South Western Hospital in London.

Available in either VHS format (£20 postpaid) or NTSC format (£30 postpaid) from Barbara Webber, Sunnybank, The Platt, Amersham, Bucks HP7 0HX, United Kingdom.

Gary McPherson's **Frog Breathing** video (38 minutes, VHS format) is now available in its 2nd edition for \$30 (Canadian) or \$22 (USD). Checks or international money orders should be made payable to SelfCare and sent to SelfCare, Attn: Frog Breathing Video, Studio 231, 4808-87 Street, Edmonton, Alberta, Canada T6E 5W3 (gmcp@vlens.com).

The **Iron Lung Virtual Museum** is a fascinating Web site (http://members.xoom.com/_XOOM/lungmuseum/welcome.htm) maintained by Richard Hill, a former technical officer at the Lane-Fox Respiratory Unit at St. Thomas's Hospital in London. Primarily focused on the development and use of the British iron lung, there is additional history about the development of other iron lungs, such as the Drinker-Collins and Emerson iron lungs. ■

Calendar 1999

JUNE 11-13. Families of SMA Family and Professional Conference, Milwaukee, Hyatt Regency. Contact Families of SMA (800-886-1762, www.abacus96.com/fsma/).

JUNE 25-26. The 1999 Parent Project Duchenne Muscular Dystrophy Conference, University of California, Los Angeles. Contact The Parent Project (patfurlong@aol.com, www.parentdmd.org).

Passy-Muir Tracheostomy and Ventilator Speaking Valves: Effective Assessment and Treatment Strategies to Enhance Patient Outcomes (one-day continuing education seminars). **JUNE 26:** NY Presbyterian Hospital-Weill Cornell Medical Center, New York, New York. **AUGUST 14:** Vencor Chicago North, Chicago, Illinois. Contact Passy-Muir, Inc. (800-634-5397, 949-833-8255, info@passy-muir.com).

OCTOBER 9-13. European Respiratory Society (ERS) Annual Meeting, Madrid. Contact ERS, 1 Boulevard de Grancy, CH-1006 Lausanne, Switzerland (info@ersnet.org; www.ersnet.org).

NOVEMBER 11-14. 61st Annual Assembly and Technical Exhibition of the American Academy of Physical Medicine and Rehabilitation

(AAPM&R) in conjunction with 13th World Congress of the International Federation of Physical Medicine and Rehabilitation. Hilton Washington & Towers, Washington, DC. Contact AAPM&R, 1 IBM Plaza, Suite 2500, Chicago, IL (Illinois) 60611-3604 (312-464-9700, 312-464-0227, info@aapmr.org, www.aapmr.org).

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Inside this issue ...

IVUN Resource Directory 1998/1999 is an excellent networking tool for health professionals and both longterm and new ventilator users. Sections are dedicated to health professionals, ventilator users, equipment repair, organizations, etc. The cost is \$5 USA; \$6 Canada, Mexico, and overseas surface; \$7 overseas air. (US funds only)



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