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Section 1 – Health and Wellness

'ABCDE' to Spot Deadly Skin Cancer

The "ABCDE" method of identifying skin cancer remains highly effective, according to experts at NYU Langone Medical Center in New York City. The medical center is where the ABCDEs for melanoma detection were developed. The original ABCD guide was created in 1985 and the E was added nearly 20 years later.

The impact of the ABCDEs has been profound, creating a simple and quick guide for anyone to examine themselves. Few would argue that countless lives have been saved by the development and awareness of the ABCDEs, helping detect the most dangerous form of skin cancer while still curable with simple removal before the cancer has spread.

The ABCDEs for melanoma detection are:

- Asymmetry: one-half of the mole is unlike the other;
- Border: the mole is irregular, scalloped or poorly defined;
- Colour: a mole has variations in colour from one area to another or has different shades of tan, brown, black and sometimes white, red or blue;
- Diameter: a mole is bigger than the size of a pencil eraser; and
- Evolving: a mole that changes in size, shape or color.

Performing regular skin self-examinations using the ABCDE guide to check for warning signs of skin cancer, especially melanoma, is an important and easy way to detect suspicious lesions and spots that could be cancerous.

Source: Drugs.com, June 2014

A Blood Test for Breast Cancer

A simple blood test which predicts a woman's likelihood of suffering breast cancer is being developed by scientists. For the first time, researchers have identified a way of discovering whether a woman is at risk even if she has no genetic predisposition. Within five years, they hope to develop a test which can predict the danger of breast or ovarian concern for up to a decade ahead.

The study, by scientists at University College London, found that women who developed hereditary breast cancer, caused by a BRCA1 mutation, had the same changes to molecules in their blood as others who developed the disease despite having no genetic predisposition. The changes were found several years before diagnosis.

Around 10% of breast cancers are caused by BRCA1 and BRCA2 gene variants inherited from parents, but the rest are unexplained. Until now there has been no reliable way to predict a likelihood of non-inherited breast cancer.

The “switch” discovered by scientists is part of a process that cause genes to be turned on or off. It is influenced by factors including alcohol and smoking, so women who knew they were more likely to develop breast cancer could adopt changes to their lifestyle, experts said. The changes could be detected in blood samples years before symptoms develop, the study suggests. Their results appear in the online journal *Genome Medicine.*

According to the Canadian Breast Cancer Foundation, breast cancer continues to be the most common cancer diagnosis in Canadian for women over the age of 20, with one in four cancer diagnoses being breast cancer in 2013.

Source: The National Post, June 2014

Breathalyzer Test for Cancer

Lung cancer causes more deaths in the United States than the next three most common cancers combined (colon, breast, and pancreatic). The reason for the striking mortality rate is simple: poor detection. Lung cancer attacks without leaving any fingerprints, quietly afflicting its victims and metastasizing uncontrollably, to the point of no return.

Now a new device developed by a team of Israeli, American, and British cancer researchers may turn the tide by both accurately detecting lung cancer and identifying its stage of progression. The breathalyzer test, embedded with a "NaNose" nanotech chip to literally "sniff out" cancer tumors, was developed by Prof. Nir Peled of Tel Aviv University's Sackler Faculty of Medicine, Prof. Hossam Haick (inventor) of the Technion - Israel Institute of Technology, and Prof. Fred Hirsch of the University of Colorado School of Medicine in Denver.

The study was conducted on 358 patients who were either diagnosed with or at risk for lung cancer. The participants enrolled at UC Denver, Tel Aviv University (TAU), University of Liverpool, and a Jacksonville, Florida, radiation center. Other researchers included Prof. Paul Bunn of UC Denver; Prof. Douglas Johnson, Dr. Stuart Milestone, and Dr. John Wells in Jacksonville; Prof. John Field of the University of Liverpool; and Dr. Maya Ilouze and Tali Feinberg of TAU.

"Our NaNose was able to detect lung cancer with 90% accuracy even when the lung nodule was tiny and hard to sample. It was even able to discriminate between subtypes of cancer, which was unexpected," said Dr. Peled.

Lung cancer tumors produce chemicals called volatile organic compounds (VOCs), which easily evaporate into the air and produce a discernible scent profile. Prof. Haick harnessed nanotechnology to develop the highly sensitive NaNose chip, which detects VOCs in exhaled breath. In four out of five cases, the device differentiated between benign and malignant lung lesions and even different cancer subtypes.

The device and subsequent analysis accurately sorted healthy people from people with early-stage lung cancer 85% of the time, and healthy people from those with advanced lung cancer 82% of the time. The test also accurately distinguished between early and advanced lung cancer 79% of the time.

The Boston-based company Alpha Szenszor has licensed the technology and hopes to introduce it to the market within the next few years. Meanwhile, a new, smaller version of the device has since been developed that can plug into a computer's USB port.

Source: American Friends of Tel Aviv University, June 2014

Canada Needs National Palliative Care Plan

The Canadian Medical Association (CMA) is calling for the creation of a national palliative-care strategy to ensure people across the country have access to a high-quality, dignified end-of-life experience. The CMA is also warning that strong safeguards must be put in place if physician-assisted dying is legalized in Canada. In June, Quebec became the first province to allow physician-assisted death.

The association made the call in a national report, “End-of-Life Care: A National Dialogue,” created after town-hall meetings were held across the country to solicit opinions on such highly charged issues as physician-assisted dying and palliative care. The report urges all Canadians to discuss their end-of-life wishes with family members and create an advance-care directive, which sets out what steps should be taken in the event they are incapacitated.

The report also notes Canadians are “diametrically opposed” when it comes to legalizing assisted suicide. Physician-assisted dying refers to doctors knowingly administering or providing a patient with the means to end his or her own life. Under federal law, assisted suicide is considered a criminal act.

The CMA report says restrictions should be put in place if physician-assisted death is allowed. Quebec’s newly passed Bill 52 states that an individual requesting medical help to end his or her life would have to be a terminally ill adult of sound mind in constant and unbearable pain, and in “an advanced state of irreversible decline in capabilities.”

Although the federal government doesn’t appear willing to reopen the debate, CMA president Louis Hugo Francescutti said the Quebec legislation will force the federal government to have a discussion on assisted suicide “whether they like it or not.”

Later this year, the Supreme Court will hear arguments in an appeal case looking to legalize assisted suicide. And Conservative MP Steven Fletcher, who is a quadriplegic, has put forward private member’s bills that seek to legalize doctor-assisted death in some cases.

Any legislation allowing physician-assisted death does not negate the need for proper palliative care services, and right now, even in Quebec, access to those services is often lacking.
A national strategy should ensure that Canadians have access to pain and symptom management that places a priority on quality of life, whether they live in urban centres or in remote, rural communities that often lack palliative care services.

Palliative care, which can be offered in conjunction with treatment for a disease or as a patient is dying, focuses on helping patients maintain quality of life by treating pain and preventing suffering. Even though surveys show most Canadians want to die at home, the majority die in

hospitals while hooked up to machines, unable to spend quality time with family members or friends. Too often, the report says, the health-care system is focused on technology, machines and curing or treating disease rather than the emotional and physical well-being of the patient. Another major challenge, according to the report, is the fact doctors do not receive extensive pain-management or palliative-care training.

Source: The Globe and Mail, June 2014

Memory Loss: When to Seek Help

Everyone forgets things at some time. How often have you misplaced your car keys or forgotten the name of a person you just met? Some degree of memory problems, as well as a modest decline in other thinking skills, is a fairly common part of aging. There's a difference, however, between normal changes in memory and the type of memory loss associated with Alzheimer's disease and related disorders.

Normal age-related memory loss doesn't prevent you from living a full and productive life. For example, you may forget a person's name, but recall it later in the day. You might misplace your glasses occasionally. Or maybe you find that you need to make lists more often than in the past in order to remember appointments or tasks. These changes in memory are generally manageable and don't disrupt your ability to work, live independently or maintain a social life. The word "dementia" is an umbrella term used to describe a set of symptoms, including impairment in memory, reasoning, judgment, language and other thinking skills. Dementia begins gradually in most cases, worsens over time and significantly impairs a person's abilities in work, social interactions and relationships.

Often, memory loss is one of the first or more-recognizable signs of dementia. Other early signs may include:

- Asking the same questions repeatedly;
- Forgetting common words when speaking;
- Mixing words up, saying "bed" instead of "table," for example;
- Taking longer to complete familiar tasks, such as following a recipe;
- Misplacing items in inappropriate places, such as putting a wallet in a kitchen drawer;
- Getting lost while walking or driving around a familiar neighborhood;
- Undergoing sudden changes in mood or behavior for no apparent reason; or
- Becoming less able to follow directions.

Mild cognitive impairment is a notable change in thinking skills that's limited, for the most part, to a narrow set of problems, such as impairment only in memory. Changes in concentration, attention or mental quickness may also be observed. Mild cognitive impairment generally doesn't prevent a person from carrying out everyday tasks and being socially engaged.

Researchers and physicians are still learning much about mild cognitive impairment. For many people, the condition eventually progresses to Alzheimer's disease or another disorder causing dementia. Other people experience little progression in memory loss, and they don't develop the whole spectrum of symptoms associated with dementia.

Many medical problems can cause memory loss or other dementia-like symptoms. Most of these conditions can be successfully treated, and your doctor can screen you for conditions that cause reversible memory impairment.

Possible causes of reversible memory loss include:

- Medications - A single medication or a certain combination of medications may result in forgetfulness or confusion;
- Minor head trauma or injury - A head injury from a fall or accident, even an injury that doesn't result in a loss of consciousness, may cause memory problems;
- Depression or other mental health disorders - Stress, anxiety or depression can cause forgetfulness, confusion, difficulty concentrating and other problems that disrupt daily activities;
- Alcoholism - Chronic alcoholism can seriously impair mental abilities. Alcohol can also cause memory loss by interacting with medications;
- Vitamin B-12 deficiency - Vitamin B-12 helps maintain healthy nerve cells and red blood cells. A vitamin B-12 deficiency, common in older adults, can cause memory problems;
- Hypothyroidism - An underactive thyroid gland (hypothyroidism) slows the processing of nutrients to create energy for cells (metabolism). Hypothyroidism can result in forgetfulness and other thinking problems; or
- Tumors - A tumor in the brain may cause memory problems or other dementia-like symptoms.

If you're concerned about memory loss, see your doctor. He or she can conduct tests to judge the degree of memory impairment and diagnose the cause. Getting a prompt diagnosis is important, even if it's a challenging step. Identifying a reversible cause of memory impairment enables you to get appropriate treatment. Your doctor can help you identify appropriate community resources and organizations, such as the Alzheimer's Association, to help you cope with memory loss and other dementia symptoms.

Source: Mayo Clinic, June 2014

Ontario's Eldercare Laws under Review

Despite increasing dementia rates among the population, early findings of an influential review suggest the provincial laws that dictate how decisions are made for seniors who can no longer decide for themselves are poorly understood, difficult to navigate and can lead to bitter family disputes.

In a discussion paper released in June, the Law Commission of Ontario, an independent body created to recommend law reform, has laid the foundation for significant change in a largely hidden but vital corner of legislation.

The law commission is launching public consultations over the summer to give people an opportunity "to tell us their stories, experiences and hopes for change," said Lauren Bates, who

is heading the comprehensive review of the laws around legal capacity, decision-making and guardianship.

The number of Canadians with some form of dementia is expected to double in the next 20 years, from 740,000 to 1.4 million. Yet the commission's initial consultations point to a profound lack of education and understanding about the complex web of laws that govern eldercare.

Under the legislation, if a senior (or any person, for that matter) is incapable of making a personal care decision, this responsibility falls to a substitute decision-maker. A senior can elect his or her substitute decision-maker for personal care and finances by creating a power of attorney, which is designed to be accessible and does not require a lawyer to complete.
If no power of attorney exists, there is a hierarchy of substitute decision-makers that begins with a spouse or common-law partner, and then continues with adult children and other relatives before ending with the province.

However, the law commission's early findings suggest that because the process is so accessible, seniors may fail to grasp that the best person for the job may not be their closest relative. Meanwhile, unlike some other jurisdictions, Ontario has no mechanisms to keep track of substitute decision-makers, actively monitor their decisions or even inform them that they have been placed in this important role. The result is a sort of honour system, in which problems are often missed until a crisis occurs.

Family conflicts are another major concern. The law commission is looking at other models. In Australia, for instance, these types of family disputes are resolved in tribunals, which cost less and are more expeditious. In some parts of the United States, meanwhile, court volunteers help families through the system.

Source: thestar.com, June 2014

Average Cost of Health Care in Canada

A typical Canadian family with two parents and two children will pay up to $11,786 for public health care in 2014, finds a new study released today by the Fraser Institute, an independent, non-partisan Canadian public policy think-tank. The study, The Price of Public Health Care Insurance, helps Canadians better understand health care costs and the value they receive for their tax dollars.

Most Canadians are unaware of the true cost of health care because they are not billed for any portion of physician and hospital services covered by tax-funded health care insurance. Moreover, general government revenue, not a dedicated tax, bankrolls health care, while health care premiums (where applied among provinces) cover only a fraction of health care costs.
However, using data from Statistics Canada and the Canadian Institute for Health Information, the study estimates the amount of taxes Canadian families will pay for public health insurance in 2014, and by how much it has increased over the last decade. For example:

- In 2014, the average single individual earning roughly $42,000 will pay $4,381 for public health care insurance.
- A family of two adults and two children earning approximately $118,000 in 2014 will pay $11,786 for public health care insurance.

And what about the cost of health care insurance among income groups?

- The 10% of Canadian families with the lowest income will pay an average of $523 for public health care insurance in 2014.
- In 2014, the 10% of Canadian families with an average income of $57,818 will pay an average of $5,522.
- And families among the top 10% of income earners in Canada will pay $37,239 for public health care insurance.

Finally, between 2004 and 2014, the cost of health care insurance for the average Canadian family (all family types) increased by 53%, dwarfing increases in income (34%), shelter (40.7%), clothing (33.4%) and food (15.6%).

Source: Fraser Institute, July 2014

Control High Blood Pressure without Medication

If you've been diagnosed with high blood pressure (a systolic pressure, the top number, of 140 or above or a diastolic pressure, the bottom number, of 90 or above), you might be worried about taking medication to bring your numbers down. Lifestyle plays an important role in treating your high blood pressure. If you successfully control your blood pressure with a healthy lifestyle, you may avoid, delay or reduce the need for medication.

Here are ten lifestyle changes you can make to lower your blood pressure and keep it down.

1. Lose extra pounds and watch your waistline - Blood pressure often increases as weight increases. Losing just ten pounds (4.5 kilograms) can help reduce your blood pressure. In general, the more weight you lose, the lower your blood pressure.
2. Exercise regularly - Regular physical activity, at least 30 to 60 minutes most days of the week, can lower your blood pressure by four to nine millimeters of mercury (mm Hg). And it doesn't take long to see a difference.
3. Eat a healthy diet - Eating a diet that is rich in whole grains, fruits, vegetables and low-fat dairy products and skimps on saturated fat and cholesterol can lower your blood pressure by up to 14 mm Hg. This eating plan is known as the Dietary Approaches to Stop Hypertension (DASH) diet.
4. Reduce sodium in your diet - Even a small reduction in the sodium in your diet can reduce blood pressure by two to eight mm Hg. The recommendations for reducing sodium are to limit sodium to 2,300 milligrams (mg) a day or less. A lower sodium level, 1,500 mg a day or less, is appropriate for people 51 years of age or older, and individuals of any age who are African-American or who have high blood pressure, diabetes or chronic kidney disease.

5. Limit the amount of alcohol you drink - Alcohol can be both good and bad for your health. In small amounts, it can potentially lower your blood pressure by two to four mm Hg. But that protective effect is lost if you drink too much alcohol, generally more than one drink a day for women and men older than age 65, or more than two a day for men age 65 and younger.
6. Avoid tobacco products and secondhand smoke - On top of all the other dangers of smoking, the nicotine in tobacco products can raise your blood pressure by ten mm Hg or more for up to an hour after you smoke. Smoking throughout the day means your blood pressure may remain constantly high.
7. Cut back on caffeine - The role caffeine plays in blood pressure is still debatable. Drinking caffeinated beverages can temporarily cause a spike in your blood pressure, but it's unclear whether the effect is temporary or long lasting.
8. Reduce your stress - Stress or anxiety can temporarily increase blood pressure. Take some time to think about what causes you to feel stressed, such as work, family, finances or illness. Once you know the cause, consider how you can eliminate or reduce stress.
9. Monitor your blood pressure at home and make regular doctor's appointments - Learning to self-monitor your blood pressure with an upper arm monitor can help motivate you. Regular visits to your doctor are also likely to become a part of your normal routine.
10. Get support from family and friends - Supportive family and friends can help improve your health. They may encourage you to take care of yourself, drive you to the doctor's office or embark on an exercise program with you to keep your blood pressure low.

Source: Mayo Clinic, July 2014

Eye Test for Alzheimer’s

Simple regular eye tests could be used to identify Alzheimer’s disease at a very early stage, research suggests. Early trials of two techniques show that a biomarker for the disease can be identified in the retina and lens of the eye. Both methods were able to distinguish between healthy volunteers and those likely to be suffering from Alzheimer’s disease with a high level of accuracy.

Researchers said the findings could be a “game changer” in the diagnosis and treatment of the condition. They said the tests could be used as part of regular eye checks by opticians.

In both studies, carried out in Australia and in the US, scientists looked for signs of beta-amyloid protein, which forms clumps in the brains of Alzheimer’s patients and is a key indicator of the disease. Both eye tests correctly identified Alzheimer’s disease with up to 85% accuracy.

Dr Simon Ridley, the head of science at Alzheimer’s Research UK, said: “The research is promising but is in the very early stages.”

Source: Canada.com, July 2014

Hospitals Parting with Visiting Hours

In 2010, Kingston General Hospital followed an increasingly widespread trend in the United States and became one of the first hospitals in Canada to do away with visiting hours, a move at

least 20 other hospitals and health-care facilities across the country have since followed and which others are considering. The open-door approach is one element of a larger move toward putting patients and their families, as opposed to doctors and nurses, at the centre of hospital culture, a shift that "patient engagement" proponents say helps the ill get better faster.

That idea is as appealing to some as it is repellent to others. Supporters see it as a way to involve families more intimately in their loved ones' healing, while opponents worry that an around-the-clock parade of visitors could spread infectious disease, disrupt other patients and put unnecessary pressure on nurses and security staff. The Institute for Patient and Family Centered Care (IPFCC), the major U.S. organization advocating the end of visiting hours, says those fears have not come to pass in the American hospitals that welcome family and friends day and night.

In 2008 and 2009, about three-quarters of all hospitals and 90% of ICUs in the United States restricted visitors in some fashion, according to a study of 606 hospitals published last year in the journal *Critical Care*. A survey conducted this year by the research and education arm of the American Hospital Association found 42% of hospitals in the U.S. reported restrictive-visiting-hour policies, which suggests the open-hours trend has spread over the last six years. (It should be noted, however, that the 2014 survey was not a straight replication of the 2008-2009 study, making it difficult to draw firm conclusions.)

In Canada, nobody is keeping track of the number of hospitals that have done away with visiting hours. But, at least anecdotally, it appears that more are giving it a try. Island Health, the health authority on Vancouver Island, made the change a few years ago; Quinte Health Care, a network of four hospitals in and around Belleville, Ont., announced the end of visiting hours last October; and Providence Health Care, a network of 16 facilities in Vancouver, officially followed in December.

Shifting that mentality can be challenging, especially for nurses and other frontline workers who are already overburdened.

Leaving it to nurses to exercise their judgment is a cornerstone of the family-presence approach. Common sense is supposed to prevail. All such policies include provisos allowing staff to ask visitors to quiet down or leave if they are bothering other patients in shared rooms, or if neighbouring patients need privacy during sponge baths or when hearing about test results. The policies also advise sick visitors to stay away, which has helped keep the open-door approach from opening the way for more infectious disease outbreaks linked to guests.

The upside, meanwhile, is that family support can be as practical as it is comforting. Relatives and friends help patients to the bathroom, track their medications and watch how wounds are dressed so they can repeat the procedure when patients are sent home.

Source: The Globe and Mail, July 2014

Canada's Nursing Workforce Continues to Grow

Contrary to concerns about a shortage in Canada, the number of regulated nurses across the country is continuing to rise, according to a recent report from the Canadian Institute for Health Information (CIHI). *Regulated Nurses, 2013* reports that last year, there were more than 408,000 regulated nurses eligible to practise in Canada, an increase of more than 8% in the last five years. In fact, the growth in the supply of nurses since 2009 has outpaced the growth of the Canadian population, which increased by 4.5% in that same time period.

CIHI's report also shows that more new nursing graduates are entering the workforce and older nurses are staying in the workforce longer.

A closer look at the numbers across Canada reveals that, since 2003:

- The supply of licensed practical nurses (LPNs) has grown by more than 50%;
- The supply of registered nurses (including nurse practitioners) has grown by 15%; and
- The supply of registered psychiatric nurses (RPNs) has grown by 8%.

Regulated Nurses, 2013 is CIHI's annual report on the supply, employment and demographic trends of Canada's nursing workforce.

Source: Canadian Institute for Health Information, July 2014

Scientists Build Pacemaker from the Heart Cells

Cardiologists at the Cedars-Sinai Heart Institute in Los Angeles have just announced a discovery that's been 12 years in the making, one that eventually could do away with the need for electronic pacemakers, which help the heart keep a beat. In what's being called a first, the team of scientists reprogrammed heart cells in a living animal (in this case, in pigs, which have hearts that resemble ours) to make a "biological pacemaker" that keeps the heart beating, all on its own.

Each year in Canada, more than 20,000 pacemakers are implanted, according to the Canadian Institute for Health Information; these devices send electrical pulses to the heart if it's beating too slowly, or skips a beat.

"Electronic pacemakers have revolutionized the care of patients with slow or abnormal heart rhythms," said Megan Frisk, editor at the journal *Science Translational Medicine*, where the study is published. "But these devices can become infected, or break." According to Dr. Eduardo Marbán, lead author on the study: About 2% of the 300,000 U.S. patients who receive a pacemaker each year are affected. Another group could benefit from biological pacemakers, too: babies in the womb who suffer from congenital heart block, which often results in stillbirth, and can't receive a traditional pacemaker.

With an eye to initially helping these patients, cardiologists pioneered a new type of therapy, first honing in on a gene called TBX18. Pigs with complete heart block were injected with the gene through a catheter. There, it converted ordinary heart cells, of which humans have billions, into specialized beat-keeping cells, which are much more rare. Within 48 hours, the

pigs' heartbeats were faster and stronger, a change that persisted through two weeks of study. Unlike pigs that received artificial pacemakers, those with biological ones had a faster heart rate when they exercised, and a slower one when they were at rest.

Before trying this in human patients, more work is needed to confirm the technique's safety and efficacy. If all goes well, they hope to start human trials within three years. One day, it could do away with the need for electronic pacemakers altogether, and usher in a new type of medicine, where patients are routinely treated with the building blocks of their own bodies.

Source: Maclean's, July 2014

How to be Happy

Do you know how to be happy? Or are you waiting for happiness to find you? Despite what the fairy tales depict, happiness doesn't appear by magic. It's not even something that happens to you. It's something you can cultivate. Start discovering how to be happy.

Only 10% or so of the variation in people's reports of happiness can be explained by differences in their circumstances. It appears that the bulk of what determines happiness is due to personality and, more importantly, thoughts and behaviors that can be changed. So, yes, you can learn how to be happy, or at least happier.

Although you may have thought, as many people do, that happiness comes from being born rich or beautiful or living a stress-free life, the reality is that people who have wealth, beauty or less stress are not happier on average than those of who don't enjoy those blessings. People who are happy seem to intuitively know that their happiness is the sum of their life choices, and their lives are built on the following pillars:

- Devoting time to family and friends;
- Appreciating what they have;
- Maintaining an optimistic outlook;
- Feeling a sense of purpose; and
- Living in the moment.

If you have been looking for happiness, the good news is that your choices, thoughts and actions can influence your level of happiness. It's not as easy as flipping a switch, but you can turn up your happiness level. Here's how to get started on the path to creating a happier you. Surround yourself with happy people. Being around people who are content buoys your own mood. And by being happy yourself, you give something back to those around you. Friends and family help you celebrate life's successes and support you in difficult times. Although it's easy to take friends and family for granted, these relationships need nurturing.

Build up your emotional account with kind words and actions. Be careful and gracious with critique. Let people know that you appreciate what they do for you or even just that you're glad they're part of your life.

Gratitude is more than saying thank you. It's a sense of wonder, appreciation and, yes, thankfulness for life. It's easy to go through life without recognizing your good fortune. Often, it takes a serious illness or other tragic event to jolt people into appreciating the good things in their lives.

Make a commitment to practice gratitude. Each day identify at least one thing that enriches your life. When you find yourself thinking an ungrateful thought, try substituting a grateful one. Let gratitude be the last thought before you go to sleep and your first thought when you wake up in the morning.

Develop the habit of seeing the positive side of things. Bad things do happen, but you don't have to let the negatives color your whole outlook on life. Remember that what is right about you almost always trumps what is wrong.

If you're not an optimistic person by nature, it may take time for you to change your pessimistic thinking. Start by recognizing negative thoughts as you have them.

Having a goal provides a sense of purpose, bolsters self-esteem and brings people together. What your goal is doesn't matter as much as whether the process of working toward it is meaningful to you.

Try to align your daily activities with the long-term meaning and purpose of your life. Research studies suggest that relationships provide the strongest meaning and purpose to your life. So cultivate meaningful relationships.

Don't postpone joy waiting for a day when your life is less busy or less stressful. That day may never come. Instead, look for opportunities to savor the small pleasures of everyday life. Focus on the positives in the present moment, instead of dwelling on the past or worrying about the future

Source: Mayo Clinic, August 2014

Mall Walking

Trying to maintain a healthy lifestyle through walking? As we approach cooler weather in the upcoming winter months, consider a “mall walking” program. It's a free, indoor, year-round option for physical activity.

Walking, along with exercise-based cardiac rehabilitation programs, is widely recommended as part of the continuum of cardiovascular care. Walking is an excellent way to prevent cardiovascular diseases and future cardiac events.

Studies have shown that walking 2.5 hours per week (30 minutes, 5 days per week) cuts the risk of developing cardiovascular and coronary heart diseases by 50%.

Source: Cardiac Health Foundation of Canada, August 2014

Speedy Delivery of Drug Helps Avoid Disability

Another study confirms that "time is brain" when treating stroke patients with a powerful clot-busting drug, tPA. Prompt treatment with tissue plasminogen activator (tPA, also known as alteplase) "is a very effective means of limiting the degree of disability in stroke patients," study co-author Dr. Jonathan Emberson, of University of Oxford in the U.K., said in a news release from the journal *The Lancet*. The study, published in the journal on August 5, 2014, also reinforces the idea that the quicker that patients can get tPA, the better.

In the study, Emberson's team looked at data from more than 6,700 stroke patients who took part in nine clinical trials involving tPA. The likelihood of a good outcome, defined as no significant disability three to six months after stroke, were 75% higher for patients who received the drug within three hours of initial stroke symptoms, compared with patients didn't get tPA.

While that three-hour window is ideal, even patients who got tPA a bit later received some benefit. For example, the chances of a good outcome were still 26% higher among patients who received the clot-buster within 4.5 hours of the attack, and 15% higher for those who received the drug more than four to five hours after initial stroke symptoms, the group found.

The benefits of quick treatment with tPA were seen in all patient groups, including those older than 80 and those with severe strokes, the authors add.

There was a slight added risk with the drug, however: the researchers also found that tPA increased the risk of dying from brain bleeding by about 2% within the first few days after stroke.

Source: Drugs.com, August 2014

Walmart Seeks Foothold in Primary Care Services

Walmart has opened six primary care locations in South Carolina and Texas, and plans to open another six by the end of the year. The clinics, it says, can offer a broader range of services, like chronic disease management, than the 100 or so acute care clinics leased by hospital operators at Walmarts across the country.

With its vast rural footprint, Walmart is positioning its primary care clinics in areas where doctors are scarce, and where medical care, with or without insurance, can be prohibitively expensive. If they succeed, the company said, it is prepared to open even more.

But while experts agree that increased access to health care is a good thing, others say patients with chronic conditions need complex care that retail giants cannot provide. Diseases like diabetes, for example, can result in complications that are not easy to manage. For patients with complex issues, the goal was for Walmart to be a patient’s first stop and part of a continuum of care.

Along with medical assistants, nurse practitioners, who generally receive less training than doctors but can prescribe most of the same medications, run the primary clinics.

While each Walmart primary care clinic has a supervisory physician who oversees compliance and prescription orders at one or two locations, those doctors do not actually treat patients. The system is the same as for acute care clinics that treat minor skin infections or a sprained ankle, but it is more unusual for facilities that provide more complicated health services.

Source: The New York Times, August 2014

Section 2 – Drug Information and Update

Dangers of Off-label Drug Use

A 15-year-old girl who wanted to clear her acne was prescribed the antibiotic minocycline. The teen developed lupus-like symptoms, her immune system attacked her own tissues and organs, and she died. The drug was not approved for this use by Health Canada.

A 23-year-old woman with "irritability" was given the anticonvulsant drug valproic acid. The medication was not approved for a patient with her condition. She developed a kidney cyst and a nervous system disorder before her kidneys failed. She died.

An 85-year-old man received the antipsychotic drug Seroquel to treat insomnia. This use was not approved. Neither the drug company nor Health Canada had enough scientific evidence to claim the pills could safely treat sleep disorders. The man suffered diarrhea and nausea before dying from a heart attack, which a doctor suspected was caused by the drug.

These cases are just a few of the hundreds of recent reports of side-effects suspected to have been caused by the "off-label" prescribing of antipsychotics, anti-inflammatories and other popular drugs in Canada. Off label means a drug is being used for a condition or age group for which it has not been approved. Doctors across Canada routinely give powerful drugs to vulnerable patients, often without strong scientific evidence proving the drugs will be safe or effective, and sometimes despite warnings that such prescribing could cause serious harm.

Drug companies in the United States have been investigated for illegally promoting off-label uses to prescribers and have paid billions in fines, but Health Canada does not appear to be probing if that is happening here.

The FDA, which accepts side-effect reports from Canada and around the world, discloses to the public whether the drugs cited in the reports are prescribed for unapproved uses. This means the FDA database shows that, in the case of the 15-year-old Canadian girl who died after taking minocycline, the drug was prescribed off label.

The Star's analysis revealed nearly 400 cases from 2010 to 2013 that involve a wide and disturbing range of reported side-effects: deaths, heart attacks, strokes, birth defects, organ failures and "spontaneous" abortions.

Like the FDA, Health Canada collects this prescription data but scrubs the fact the use was off label from the reports before publishing them in its public side-effects database. This information could help doctors and patients make better prescription decisions. Numerous doctors, top medical researchers and lawmakers interviewed by the Star had no idea Health Canada collects this crucial data. Health Canada has been collecting this information for six years but said technical limitations with the database have prevented their public release.

There are innovative off-label uses of drugs that have helped patients, but many off-label prescriptions are written with no solid scientific proof that the drug will be safe or effective.

In the U.S. database, the Star found more than 20 Canadian side-effect reports saying the off-label prescription was “ineffective” or “aggravated” the patient’s condition. The Canadian cases in the FDA database likely represent just a fraction of the actual number of cases where off-label drugs are thought to be the cause of serious side-effects in Canada. Side-effects are grossly under reported, and only a small number of those from Canada make their way into the U.S. database.

Health Canada says it is the responsibility of doctors to safely prescribe medications, using their expertise and experience to determine whether an unapproved use is right for a patient. Doctors should also know a drug’s risks, and experts say side-effect reports with information about unapproved uses would help build what is known as a medication’s safety profile.

Doctors may also learn of potential off-label drug uses from pharmaceutical sales reps, though it is illegal for drug companies to promote unapproved uses of their products. A 2013 study, which found a troubling pattern of off-label discussions between sales reps and Canadian doctors, suggests there is a problem.

Source: thestar.com, June 2014

U.S. FDA Warns of Problems at Quebec Flu Vaccine Plant

Canada’s largest supplier of flu vaccine is the target of a lengthy warning letter from the U.S. Food and Drug Administration, accusing the supplier of failing to follow the appropriate quality control practices and insufficiently addressing concerns raised by inspectors. The agency inspected the GlaxoSmithKline Inc. flu vaccine plant in Ste-Foy, Que., which supplies vaccine to Canadian and American customers, in March and April this year. Inspectors documented a failure to follow American drug manufacturing guidelines and an inadequate water purification regime.

While the FDA issued a lengthy public warning letter, it’s unclear if Health Canada ever found similar results in its inspections. The Canadian agency completed two inspections of the GSK facility recently: one in 2012 and one in June 2014.

In the 2013 flu season, more than five million doses of flu vaccine were supplied by GSK to the Canadian government, according to a company spokesperson. The company has a 10-year, $425-million contract to supply the vaccine.

While the FDA posted its warning notice online, Health Canada did not provide a copy of the 2012 inspection report when asked. A spokesperson was not able to immediately answer a question about whether or not the agency found any infractions in 2012.

Health Canada said the FDA warning does not affect any flu vaccines currently on the market and said the risk to consumers is “low.” GlaxoSmithKline said in a statement that it tests each batch of vaccine before it leaves the factory.

Source: The star.com, June 2014

Understanding Subsequent Entry Biologics

Biologics are a class of drug derived through the metabolism of living organisms, rather than being synthesized in a laboratory. Biologics are often used to treat cancer, rheumatoid arthritis, and diabetes. They include insulin analogues, interferons, erythropoietin, and monoclonal antibodies such as infliximab, adalimumab, or trastuzumab. In 2010, biologics accounted for 14% of the Canadian pharmaceutical market, and their use is expected to grow.

As patents begin to expire, new versions of these drugs will come to market, modeled closely on those previously approved. These are called subsequent entry biologics (SEBs) in Canada, biosimilars in Europe, and follow-on biologics in the United States. Like traditional generic drugs, SEBs have the potential to decrease health care costs.

But, unlike traditional generic drugs, SEBs are not equivalent to their reference products because their chemical characteristics cannot be precisely duplicated during the manufacturing process. SEBs may have unique efficacy, immunogenicity, or safety profiles that are distinct from their reference products.

Regulators around the world are considering how best to review and approve SEBs. Health Canada requires SEB manufacturers to submit a new drug submission, rather than the abbreviated submission that can be used for traditional generics. Health Canada does not consider SEBs to be pharmaceutically equivalent to the reference product, and does not support automatic substitution of an SEB for its reference product.

Source: Canadian Healthcare Network, June 2014

Vitamin D - A Key to a Longer Life?

Higher levels of vitamin D may protect people from an earlier death, particularly from cancer and heart disease, suggests a new analysis of existing research. The opposite may also be true; low levels of vitamin D may be linked to a higher risk of premature death. But the researchers acknowledge that the review's findings aren't definitive.

People with low vitamin D die more frequently from heart disease and cancer, but it is not known if the low vitamin D is a cause of these diseases or just a byproduct of generally poor health. Still, the research published online in June in *BMJ* does hint at the possibility that vitamin D may benefit people across genders, ages and Western countries. The findings are "compellingly consistent".

Vitamin D is a hot topic in the medical world. Studies have both supported and debunked its supposed powers as a booster of lifespans. Researchers are looking forward to future studies that they expect to be more definitive.

The current analysis only examined what happened to people with various levels of vitamin D in their bodies. The studies included in this analysis didn't go a step further to randomly assign participants to take vitamin D supplements or an inactive placebo.

The researchers examined eight studies from Europe and the United States that together tracked more than 26,000 nonsmoking men and women. They were all between ages 50 and 79. About 6,700 participants died during the time period of the studies, mostly of heart disease or cancer.

Those with the lowest levels of vitamin D were about 1.5 times more likely than those with the highest levels to die from any cause and from heart disease during the periods of the studies. Those with low levels of vitamin D and a history of cancer were 1.7 times more likely to die of the disease. People who hadn't previously had cancer saw no change in the risk of cancer death by vitamin D levels.

The researchers pointed out that vitamin D may not change levels of risk for health problems and earlier deaths. It's possible that levels of vitamin D reflect overall health. Low levels of vitamin D may just be a sign of poor health rather than a cause of it, according to the study.

For now, people should follow the recommendations of the Institute of Medicine regarding vitamin D. Its 2010 report says most Americans and Canadians already get enough vitamin D. It says nothing about whether people with heart disease or cancer should take supplements, however.

Source: Drugs.com, June 2014

Aspirin Significantly Cuts Cancer Rates

Taking a small daily dose of aspirin can significantly reduce the risk of developing, or dying from, bowel, stomach and oesophageal cancer, according to a large review of scientific studies. Researchers who analyzed all available evidence from studies and clinical trials assessing benefits and harm found that taking aspirin for 10 years could cut bowel cancer cases by around 35% and deaths from the disease by 40%. Rates of oesophageal and stomach cancer were cut by 30% and deaths from these cancers by 35 to 50%.

Professor Jack Cuzick, head of the centre for cancer prevention at Queen Mary University of London, said the evidence showed that, to reap the benefits of aspirin, people need to take a daily dose of 75 to 100 milligrams for at least five years and probably up to 10 years between the ages of 50 and 65.

No benefit was seen while taking aspirin for the first three years and death rates were only reduced after five years, he and his team reported in a review in the Annals of Oncology journal.

“Our study shows that if everyone aged between 50 and 65 started taking aspirin daily for at least 10 years, there would be a 9% reduction in the number of cancers, strokes and heart attacks overall in men, and around 7% in women,” Cuzick said in a statement about the research.

But the researchers also warned that taking aspirin long-term increases the risk of bleeding in the stomach: among 60-year-olds who take daily aspirin for 10 years, the risk of digestive tract

bleeding increases from 2.2% to 3.6%, and this could be life-threatening in a small proportion of people.

Aspirin reduces the risk of clots forming in blood vessels and can therefore protect against heart attacks and strokes, so it is often prescribed for people who already suffer with heart disease and have already had one or several attacks.

Aspirin also increases the risk of bleeding in the stomach to around one patient in every thousand per year, a factor which has fuelled debate over whether doctors should advise patients to take it as regularly as every day.

Source: The Globe and Mail, August 2014

Cholesterol Drugs – Benefits Outweigh Risks

The benefits of long-term use of cholesterol-lowering statin drugs greatly outweigh the risks, according to a review of research published over 20 years. Some experts fear that statins may be overused, but these new findings could offer reassurance to the more than 200 million people worldwide who take the drugs, the review authors said. Common statin medications include Crestor, Lipitor and Zocor.

Researchers analyzed data from studies conducted since 1994 that included more than 150,000 middle-aged and elderly men and women who took statins and were followed for about five years. The results showed that long-term statin use slightly increased the risk of some side effects but did not increase the risk for others.

For example, there was little evidence of muscle aches and pains and only a slight increase in the risk of muscle inflammation. A serious condition featuring the rapid breakdown of muscle tissue was mainly associated with high doses of statins that are no longer recommended. Long-term use of statins was associated with a modest increase in the risk of type 2 diabetes, but only among people who had other diabetes risk factors. People who took statins for a long time had low increased risk for dementia, blood clots, cataracts and fatigue.

The researchers also found that statin use offered some protection for people at risk for inflammation of the pancreas and for kidney disease caused by the dye used for some medical imaging procedures.

The study was published July 31, 2014 in the *British Medical Journal*.

Source: Drugs.com, August 2014

Who Should get the Shingles Vaccine?

Whether they've had shingles or not, adults age 60 and older should get the shingles vaccine (Zostavax), according to the Centers for Disease Control and Prevention (CDC). Although the

vaccine is also approved for use in people ages 50 to 59 years, the CDC isn't recommending the shingles vaccine until you reach age 60.

The shingles vaccine protects your body from reactivation of a virus, the chickenpox (varicella-zoster) virus, which most people are exposed to during childhood. When you recover from chickenpox, the virus stays latent in your body. For unknown reasons, though, the latent virus sometimes gets reactivated years later, causing shingles. The shingles vaccine prevents this reactivation.

The shingles vaccine isn't fail-safe; some people develop shingles despite vaccination. Even when it fails to suppress the virus completely, however, the shingles vaccine may reduce the severity and duration of shingles.

The shingles vaccine is a live vaccine given as a single injection, usually in the upper arm. The most common side effects of the shingles vaccine are redness, pain, tenderness and swelling at the injection site, and headaches.

The shingles vaccine isn't recommended if you:

- Have ever had a life-threatening allergic reaction to gelatin, the antibiotic neomycin or any other component of the shingles vaccine;
- Have a weakened immune system due to HIV/AIDS, lymphoma or leukemia;
- Are receiving immune system-suppressing drugs, such as steroids, adalimumab (Humira), infliximab (Remicade), etanercept (Enbrel), radiation or chemotherapy;
- Have active, untreated tuberculosis; or
- Are pregnant or trying to become pregnant.

Source: Mayo Clinic, August 2014

Section 3 – National and Provincial Issues

PROVINCIAL ISSUES

ON - Enhancing Patient Care and Pharmacy Safety

Ontario is introducing legislation that, if passed, would strengthen the safety of drugs that are provided in the province's hospitals and further enhance patient care. The government is following through on its commitment to implement recommendations contained in Dr. Jake Thiessen's review of the province's drug supply system. In 2013, Dr. Thiessen conducted a thorough investigation into the discovery of under-dosed chemotherapy drugs at four Ontario hospitals and one in New Brunswick.

Ontario is proposing legislation which requires amendments to the Drug and Pharmacies Regulation Act, to give the Ontario College of Pharmacists the authority to inspect and license hospital pharmacies. Currently, pharmacies in the community are overseen by the Ontario College of Pharmacists, whereas hospital pharmacies are the responsibility of individual hospital corporations. Expanding the college's authority to regulate hospital pharmacies will ensure that they meet consistent standards across the province.

Specifically, the government's proposed legislation would:

- Provide the Ontario College of Pharmacists with the authority to license and inspect pharmacies within public and private hospitals, in the same manner it currently licenses and inspects community pharmacies;
- Provide the college with the ability to enforce licensing requirements with regard to hospital pharmacies;
- Allow the college to make regulations to establish the requirements and standards for licensing, operation and inspection of hospital pharmacies; and
- Provide government with the ability to extend the college's oversight to other institutional pharmacy locations in the future, as appropriate.

As a result of these changes, the Ontario College of Pharmacists will be able to conduct regular inspections of hospital pharmacies so they can monitor compliance with operational standards and licensing requirements. Currently, other provinces including British Columbia, Newfoundland and Labrador, Prince Edward Island and New Brunswick require their pharmacy regulators to license and inspect hospital pharmacies.

Ontario is also proposing changes that, if passed, would improve the health system's ability to quickly identify and respond to any future incidents that could affect patient care and safety.

The changes include:

- Enabling health regulatory colleges to more readily share information with public health authorities as may be required for the purposes of administering the Health Protection and Promotion Act;
- Permitting health regulatory colleges to share information with public hospitals, as well as other persons, in relation to an investigation of a regulated health professional employed by or who receives privileges from a hospital;
- Requiring a hospital or employer to report to health regulatory colleges where a regulated health professional has resigned or voluntarily relinquished or restricted his or her practice or privileges because of concerns regarding the member's potential professional misconduct, incompetence or incapacity;
- Allowing the government to more quickly appoint a college supervisor, where the Minister of Health and Long-Term Care considers it to be appropriate or necessary, in order to address any serious concerns regarding the quality of a college's governance and management; and
- Providing health regulatory colleges with additional flexibility to focus their investigation of public complaints on matters that could, if established, constitute professional misconduct, incompetence or incapacity.

Source: Ontario Ministry of Health and Long-Term Care, July 2014

BC - Age-friendly Recognition for Eight Communities

Parliamentary Secretary for Healthy Living and Seniors, Michelle Stilwell, announced that eight B.C. communities will receive Age-friendly BC Recognition awards for 2014. Local governments in Anmore, Cobble Hill (Cowichan Valley Regional District), Granisle, Kent, Kitimat, Telkwa, Vancouver and Vanderhoof will each receive a $1,000 award to create a legacy project or celebration, as well as an Age-friendly BC Recognition award poster.

To achieve Age-friendly BC Recognition, communities must complete four steps. These include establishing an advisory committee, passing a local government resolution, conducting an age-friendly assessment, and developing and publishing an action plan. The participation of local seniors also is required and is an integral part of this process.

In Cobble Hill, for example, a project report was developed that included an age-friendly assessment and recommended actions, particularly related to safety, transportation and housing. Implementation has begun with the creation of a seniors' lunch program, work on a potential seniors' housing development and accessibility improvements for local parks and trails.

The Age-friendly BC Recognition program is a partnership between the BC Healthy Communities Society and the Ministry of Health and is part of the provincial Age-friendly BC strategy. A total of 25 communities now have received Age-friendly BC Recognition. For a complete list of age-friendly recognized, please visit: www.gov.bc.ca/agefriendly

Source: Government of British Columbia, July 2014

BC - First-in-Canada Community-care Licensing Program

The Advanced Specialty Certificate in Community Care Licensing at the Justice Institute of British Columbia (JIBC), a one-of-a kind program in Canada, received a boost with $600,000 in provincial funding.

“With the growing seniors' population in B.C. and a number of child-care facilities, there is an increasing need for residential facilities and community-care licensing inspectors to ensure that facilities provide the best and safest care,” said Health Minister Terry Lake. “Investing in the certification of these inspectors now is a proactive step towards filling a future need in our communities. While this is not an overnight change, it will sustain training, consistency of practice and accountability over the coming years.”

The funding will help train new licensing officers and support existing officers in upgrading their skills through enrolment in the Advanced Specialty Certificate in Community Care Licensing. The specialized role of community-care licensing officers helps protect B.C.’s most vulnerable residents. These licensing officers are employed by health authorities to inspect and monitor both publicly funded and private residential-care and child-care facilities. They also provide education and support to licensees, conduct investigations, and take action to bring facilities into compliance with the provincial acts and regulations that govern them.

There are currently approximately 150 community-care licensing officers working through health authorities to inspect the roughly 1,050 licensed adult and child/youth residential-care facilities and 6,000 licensed child-care facilities in British Columbia.

For more information on the community-care licensing officer training, please visit www.jibc.ca/cclo.

Source: Government of British Columbia, August 2014

NATIONAL ISSUES

Improving Nutrition Information on Food Labels

Health Canada is proposing to update the Nutrition Facts table for prepackaged foods to reflect the latest scientific information, as well as changing the look of the Nutrition Facts table and the list of ingredients so that they can best help Canadians make informed choices when selecting foods for themselves and their families.

Some of the proposed changes to the Nutrition Facts table include:

- Refreshing the format to make the Nutrition Facts table easier to read and to emphasize certain elements, such as Calories, to help Canadians quickly locate this information;
- Changing the ordering of the nutrients in a way that all of the nutrients that have a % Daily Value (DV) listed in the upper part of the table are the nutrients that Canadians may

want less of, and that the nutrients with a % DV listed in the lower part of the table are the nutrients that Canadians may want more of;

- Requiring information about the amount of "added sugars" in a food product and/or adding a % DV for "total sugars" to help consumers identify if there is a lot of sugars in a food product using the education message on the % DV at the bottom of the table;
- Requiring the declaration of potassium and vitamin D, nutrients that many in the Canadian population are not getting enough of, which puts them at higher risk for chronic disease. Vitamin D is important for its role in bone health. Potassium is beneficial in lowering blood pressure. Vitamins A and C would no longer be required on the label because there is no evidence of a deficiency of these vitamins in the general population, though manufacturers could declare them voluntarily; and
- Adding a message at the bottom of the Nutrition Facts table that would read: "5% DV or less is a little, 15% DV or more is a lot". This message is in line with Health Canada's education campaign and would provide Canadians a reminder on how to use the % Daily Value.

The list of ingredients shows all the ingredients in a packaged food from most to least. It is an important tool for consumers to understand the composition of a food, but many Canadians have indicated that they often find it difficult to locate and read the list of ingredients on food labels.

Some of the proposed changes to the list of ingredients include:

- Requiring a consistent look for the list of ingredients, similar to the Nutrition Facts table; and
- Requiring the list of ingredients to appear in a distinctive box with a title, using black type on a white or neutral background for contrast, using upper and lower case letters, and having a minimum font size.

Source: Health Canada, July 2014

Safe Prescribing Practices for Drugs

The Honourable Rona Ambrose, Minister of Health, issued a national Call for Proposals to improve the prescribing practices for prescription drugs that have a high risk of abuse or addiction. Health Canada will devote $3.6 million to support the development of evidence-based practices for appropriate prescribing of the most commonly abused classes of prescription drugs: opioids, stimulants, sedatives and tranquillizers.

The Call for Proposals is aimed at projects that will improve prescribing practices and the educational needs of healthcare practitioners. It also focuses on projects that will develop new approaches, training and tools to improve these prescribing practices.

Quick Facts:

- Prescription drugs are now the third most commonly abused substance among Canadian youth, after alcohol and marijuana.
- The 2012 Canadian Alcohol and Drug Use Monitoring Survey results show opioid pain relievers are among the most commonly used prescription drugs, and almost one in six (17%) of Canadians aged 15 years and older reported the use of opioid pain relievers in the past 12 months.
- Earlier this year, Minister Ambrose co-hosted a symposium in Toronto, attended by doctors, pharmacists, law enforcement, different levels of government, addictions specialists and First Nations to discuss prescription drug abuse.
- Economic Action Plan 2014 expanded the focus of the National Anti-Drug Strategy to address prescription drug abuse in Canada. Additionally, the Government is investing nearly $45 million over five years to support new actions for that purpose.
- In June 2014, Minister Ambrose announced a proposal to regulate tamper-resistant properties for prescription drugs that are at a high risk of abuse, including controlled-release oxycodone.

Source: Health Canada, July 2014