



## INSIDE THIS ISSUE

- 2 STEROIDS**  
Why am I on them, what do they do and why do I have to reduce the dose?
- 3 WELLBEING**  
Ask the pharmacist!
- 4 RESEARCH UPDATE**  
Angus' work this summer.
- 5 FUNDRAISING UPDATES**  
Mark Nichols describes his fundraising RideLondon100 bicycle challenge!
- 5 MEMBERSHIP**  
Update plus 5 reasons to be a member
- 6 EXPERIENCES**  
Fighting inflammation with food.
- 7 PMR GCA SCOTLAND**  
News from the OMERACT Rheumatology conference in Budapest.
- 8 SUPPORT GROUP CONTACTS AND UPDATES**  
News of new Groups starting up and all the contacts you need!

 **NATIONAL HELP LINE**  
**0300 111 5090**

PMRGCAUK is a registered charity established to meet the needs of people with these debilitating conditions by raising awareness, promoting research and offering support.

## ROGER GRAEF SPEAKS OUT: **Warning! Lack of diagnosis is dangerous**



Award-winning filmmaker and criminologist Roger Graef spoke recently about his experience of PMR,

'It started with a pain in one arm, then spread around my body until I started shuffling like an old man.'

Roger's GP didn't understand it – nor did the seven physiotherapists he visited. It was only following the suggestion of a friend – an osteopath – that PMR was diagnosed and he was prescribed steroids.

Despite coming from a medical family, Roger had never heard of PMR before – an experience many readers will find very familiar.

Roger feels very lucky. After seven months he was able to decrease the steroids. However the experience left him alarmed at the lack of knowledge of the illness – both among the general public, but particularly among medical professionals.

With at least 40,000 people in the UK diagnosed with PMR every year plus the dangers associated with the late diagnosis and treatment of Giant Cell Arteritis, it is imperative that the NHS provides enough training and fast track pathways for everyone who is diagnosed. The more publicity this gets, the more likely it is to happen.

## Support Group Organisers Day

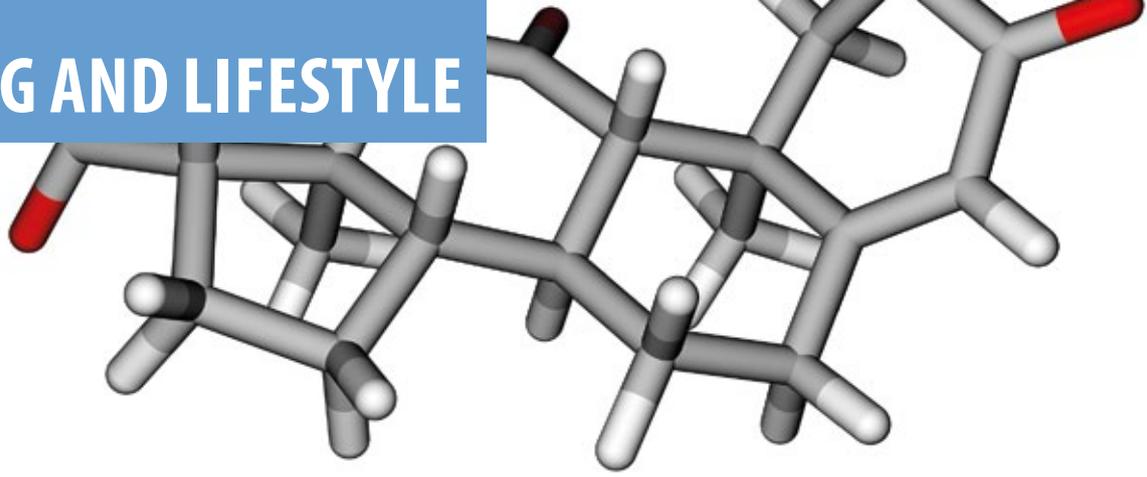


Local support groups are a vital part of PMRGCAUK and wouldn't exist without the dedication of volunteer organisers. Our annual Support Group Organisers Day will be held on October 22nd in London – a chance to meet other organisers, and get practical information and support on starting and running a group. It's also open to anyone interested in starting or supporting a group – please contact [sophy@pmrgcauk.com](mailto:sophy@pmrgcauk.com) or call 0300 999 5090 if you'd like to attend.



## FEATURED FUND RAISER: MARK NICHOLS

Meet Mark Nichols, who has been supporting PMRGCAUK since 2012. Mark's mother has been suffering with both PMR and GCA for the last few years. Find out more about Mark and his latest challenge on page 5.



## Steroids:

# Why am I on them, what do they do and why do I have to reduce the dose?

**BY EILEEN HARRISON**

Someone reading this probably has either PMR or GCA and been prescribed prednisolone. You wonder why and have heard a lot of unpleasant things about this medication. Here is a simple explanation – because not everyone is a doctor.

### WHAT IS PREDNISOLONE?

Our bodies make a substance called cortisone, it is essential for life and is a steroid – but not the sort bodybuilders use. Invented about 1950, the artificial version, prednisolone, was hailed as a miracle – arthritis patients in wheelchairs got up and walked! But the high doses they used led to many side-effects. Too much of these steroids causes Cushing's syndrome: fat deposits around your middle, back of your neck and your face, high blood pressure, problems with blood sugar control and other nasties.

The dose used for PMR/GCA is one that is more than enough to deal with the inflammation that is

causing the trouble – swelling that impairs blood flow. Only steroids work reliably to do this and in GCA they can prevent you going blind. They don't cure the underlying problem in the immune system causing your body to attack itself but the symptoms can be managed until that autoimmune problem goes into remission naturally. Meanwhile the prednisolone induces remission and you have few or no symptoms despite the real illness being active – stop prednisolone and symptoms will return.

The inflammation affects the blood vessels – a vasculitis, so muscles and nerves don't get enough oxygen causing damage leading to pain and stiffness. Your muscles have become unable to recover normally after exercise because their plumbing has been blocked! Prednisolone helps reverse that.

Enough prednisolone to control the inflammation is used - if steroids didn't have side-effects you could take that dose forever and feel great but steroids are not sweeties. They have over 80 recorded side effects, some mild, others worse and some may even be life-threatening. That doesn't make them bad drugs, all medications have side-effects. Even 'over the counter' (OTC) painkillers can damage organs if not used properly. The aim is to get you reasonably symptom-free and then reduce the prednisolone to the lowest dose that keeps YOUR symptoms under control, depending on how severe the underlying disease

is. It is still there but you are not suffering too much pain. A bit like diabetes: there isn't enough insulin for the carbohydrate eaten so you become ill, replace the insulin or make it more efficient and you won't be ill. Stop it and you will be ill again. With PMR, stop the prednisolone and the PMR pain will return.

In the UK the recommended starting dose for PMR is 15mg, occasionally 20mg/day. They often used much higher doses (some doctors still do) but 15-20mg is usually enough so you are exposed to less artificial steroid than starting at 40 or 50mg as in GCA where it is important to avoid blindness and it must be dealt with quickly. In asthma or flares in Crohn's disease prednisolone is used for only a short time so side effects are less of a problem.

### HOW IT WORKS

All over the body there are areas called receptors which respond to a particular neurotransmitter, hormone, antigen, or other substance: a bit like the electric socket that connects your iron to the electricity. The substance can't work unless attached to a receptor – only then it can have an effect on the cells.

Prednisolone binds with glucocorticoid receptors. There are 2 sorts, found in all types of tissue. They let prednisolone change how the cells make some proteins and stop production of



others. In PMR/GCA, the important effects are anti-inflammatory and immunosuppressive. This relieves symptoms but sugar production is increased, proteins and fats are broken down and bone production altered – leading to weight gain, muscle wasting, higher cholesterol and osteoporosis. They return to normal when you stop taking prednisolone (except the osteoporosis) but not quickly. The body has to get used to it so NEVER stop taking your prednisolone suddenly.

Receptors are involved in another problem, brain fog. It happens in PMR and GCA even without prednisolone – maybe due to poor blood supply to the brain – but often happens at higher doses when there is more steroid than needed to occupy all the receptors. At first you may feel quite euphoric and “high” as receptors are triggered in the part of the brain concerned with memory and learning, the hippocampus, but when they are all occupied, the leftover steroid makes you feel confused and affects your memory.

## WHAT NOW?

Once the inflammation is under control after a few weeks, the prednisolone dose must be reduced to the lowest level that still controls the symptoms, to reduce side effects whilst still allowing you a fairly normal life: not fully back to normal - despite what doctors often think - but your quality of life will be better with less pain. Prednisolone doesn't change the underlying autoimmune disorder so the fatigue it causes often persists for some time and bursitis and synovitis often take much longer to fade.

Management is key: you have to play your part by not overdoing it. Your body is intolerant of exercise and takes longer to recover – so resting and pacing yourself are essential.

Next time I will look at the best ways to get to a lower dose – our Holy Grail!

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# Ask the pharmacist!

Dott Luca Viani is a Pharmacist/Independent Prescriber, based in London, with a wide range of experience within the private sector and NHS. We received so many questions for Dott Viani that we couldn't include them all! We'll publish more in the next two issues.

**Q Are there any topical alternatives to steroids, to limit their effects closer to the areas most affected?**

**A** Topical steroids are not recommended as they are associated with other major side effects including skin atrophy. Patients suffering from PMR see different areas of their body being affected by pain and sometimes the area is large. Topical steroids are not recommended for the management of such symptoms.

**Q Is there a suspension instead of tablets so one could be more accurate with measuring small amounts of Prednisolone? (I find a pill cutter useless!)**

**A** Prednisolone preparations vary according to countries. Unfortunately the UK has not licensed any oral preparations of prednisolone. Imported oral preparation of prednisolone is unlicensed, so unpopular with prescribers. In the UK we have prednisolone soluble tablets 5 mg (as sodium Phosphate) net price (30 tablets): £42.78. It is prescribed under exceptional circumstances when a patient suffers with dysphagia (problems in swallowing), and only following consultation with the pharmacist and clinician.

**Q I have only learnt recently that I should not take Adcal and Prednisolone close together. Why?**

**A** Adcal contains calcium carbonate, which is a calcium salt used mainly to supplement calcium in the diet, and colecalciferol, otherwise known as vitamin D3. Adcal's active ingredients decrease absorption and so effectiveness of prednisolone.

**Q I have slowly reduced from 15mg to 7mg/6:5. Just had bloods done, sugar a little high. Is there a better alternative to Lansoprazole to treat Acid Reflux?**

**A** There are different type of antacids. Ranitidine could be considered a safe alternative for a patient with a history of cardiovascular episodes. Sometimes ranitidine is not effective in managing symptoms associated with steroid side effects so products like omeprazole and lansoprazole are prescribed. Other derivate products include pantoprazole, rabeprazole, esomeprazole. In a study, the newer Proton Pump Inhibitors (PPIs) Lansoprazole, rabeprazole and pantoprazole, were of similar efficacy to omeprazole in terms of heartburn control, healing rates, and relapse rates. All PPIs were superior to ranitidine and placebo in healing erosive esophagitis and decreasing relapse rates. Esomeprazole maybe more effective than omeprazole, lansoprazole and pantoprazole for the rapid relief of acid reflux symptoms. Check with your pharmacist before opting for another antacid remedy.



## RESEARCH UPDATE

# Angus' work this summer

Last issue's article 'Research – where does the money go?' reported how a generous legacy of £7000 and additional donation of £1000 from our associate charity, PMR & GCA North East, would be used to support research. The legacy was made by Mrs Mary Piggales, a longstanding member of one of the first North East support groups. The money was donated to the University of Leeds, Alumni and Development Team towards the total cost of a research project on GCA. Dr Sarah Mackie, Consultant Rheumatologist, updated us on what happened next:

"Angus Hall, who is studying Medicine at Birmingham University, has just finished a six-week summer lab placement with us in Leeds. He has been analysing patterns of inflammation in archived temporal artery biopsies from patients with GCA who have participated in our research study. Using special staining techniques, Angus has been studying these patterns of inflammation in detail, in order to help us understand

the reasons why only some people with GCA develop complications such as blindness and stroke. Analysis is ongoing and the results will be submitted to a peer-reviewed scientific journal for publication." We'll report on the results of the research in future issues.

Angus told us: "This was very exciting because I had never done anything like this before and as a medical student I was really interested in seeing the academic side of medicine. Working with researchers and scientists was very enjoyable and I learnt many new practical skills and academic skills which I will take with me for the rest of my time at university and beyond. The project itself was highly engaging as I was researching new aspects of GCA and attempted to answer a previously unanswered question about the disease. The experience of planning the project, implementing the plans and seeing the results was extremely rewarding. I thoroughly enjoyed myself during this project and feel that it has significantly added to my medical education and skillset."

Every donation or legacy can have a huge impact and help better understanding of both PMR and GCA.



HealthUnlocked



## Join our PMRGCAuk community and make your experience count

Get help to manage your health and lifestyle from others with polymyalgia rheumatica and giant cell arteritis and from the charity, PMRGCAuk.

It's free, easy to use and it's just waiting for you!

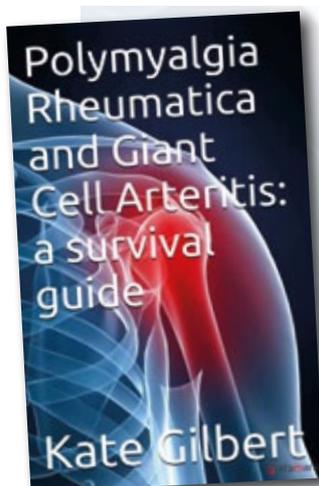
The online community gives you:

- Answers to your health questions from other patients
- Support from other PMR and GCA sufferers
- Ideas for treatment and lifestyle choices that could help
- Health issues and debates relevant to you

Take control of your health and join today



[pmrgcauk.healthunlocked.com](http://pmrgcauk.healthunlocked.com)



Since its publication this book has quickly become a bestseller. Kate Gilbert, PhD, distilled what she learned from having PMR (and recovering!), and from years of working alongside other sufferers, rheumatologists and researchers, as a trustee of PMRGCAuk. Kate says "I have tried to write the book that I would have liked to read when I had PMR, not only when I was first diagnosed, but also a few months in, when I realised that it wasn't going to be as straightforward as they had led me to believe."

It is now available in paperback from [Amazon.co.uk](http://Amazon.co.uk) ([Amazon.com](http://Amazon.com) outside the UK). Price £5.99 plus p&p. Kindle edition £4.30. Royalties from sales are donated to PMRGCAuk.

If you are unable to order the book from Amazon, write to [kate@pmrgcauk.com](mailto:kate@pmrgcauk.com) to order via PMRGCAuk. Or ask your bookshop to order a copy: ISBN-10: 1500713406 ISBN-13: 978-1500713409 Publisher: CreateSpace Independent Publishing Platform (28 Feb 2014)

We're sorry for the delay in sending out books earlier this year – with the new range of ordering options this won't happen again.

# FUNDRAISING UPDATES



Split	Time	Pace [min/mi]
EST MILE 17	43:53	02:43
EST MILE 26	01:11:10	02:53
EST MILE 47	02:17:21	03:10
DIVERSION 1	02:28:33	03:04
DIVERSION 2	02:48:47	03:05
EST MILE 75	02:58:34	02:59
EST MILE 85	03:30:57	03:06
FINISH	04:15:37	02:55

## Mark Nichols (continued from page 1)

Mark told us "None of our family were even aware the illnesses existed before she was diagnosed and the diagnosis was quite unpleasant with my mother in a considerable amount of pain, culminating in her lying on the floor in agony, unable to move one morning. The local doctors were helpful but seemed rather bemused at first. Any effort to help get people diagnosed faster and better informed seems like a great idea to me so I'm more than happy to try and help!"

Mark's reaction was to start raising money and awareness through cycling challenges. Here is his most recent experience:

"It's Monday. I'm dry. I still like cycling. I still like cycling.

It must be true if I say it enough. Yesterday was the RideLondon100. 2013 was so much fun I thought I'd ride again in 2014. In the days leading up to the event it became clear that

the beautiful weather might come to an almighty halt. Still, how much could it really rain?

At 4:30 am the alarm rings. I put on the precautionary waterproof clothing. Got to the start on time. I assumed it would be a 100 mile ride but it became apparent that the course had been reduced to 86 miles and the climbs of Leith Hill and Box Hill, the defining points, had been removed for safety. Most people reacted with a combination of disappointment and a desire to set a time on a relatively flat course.

The centre of London flashed by, as did Richmond Park. Then the rain started. On the descent from Newlands Corner it went biblical. Visibility was reduced to a few smudges of different colours ahead. It eased to a persistent, heavy rainfall. At Kingston the road looked like glass. At Wimbledon we forded the road. Then we got to Chelsea and a few miles from the finish it was hard to tell where the Thames stopped and the road started. At Lambeth Bridge - lightning

and thunder. A quick sprint down the Mall and it was over in 4 hours and 15 minutes.

When cycling for charity I've been accused of asking for charitable donations for doing something I enjoy. I'm glad to have righted that wrong by really not enjoying it this year. So, if you have already donated, thank you. If you'd like to donate, please feel free (see the link below). Otherwise, perhaps you could offer up an anti-rain dance for 2015 instead?"

[To find out how to donate, contact \[info@pmrgcauk.com\]\(mailto:info@pmrgcauk.com\)](#)

## Membership update



From September 2014 PMRGCAuk annual membership fees are being increased from £20 to £25. For unwaged members fees will remain at £10.

We are extremely thankful to all our members and those who donate funds to us. The Trustees are always very careful to keep expenditure as low as possible.

Although we have no office or staff team and all the charity's work

is carried out by volunteers who give all their time, effort and dedication freely we still have ever-increasing expenditure. Membership fees are used to pay for the Helpline, support to local groups, printing and posting of information packs and newsletters. Sometimes funds are needed for campaigning for better understanding and new research – with the goal of ensuring universally excellent treatment of both illnesses.

### WHY JOIN?

Five excellent reasons for becoming a PMRGCAuk member:

1. You will help others to receive support
2. You receive newsletters keeping you informed on research and news relating to PMR, GCA and UK support groups
3. Annual Members' Day – the perfect opportunity to come together with others UK-wide to share experiences and find out more
4. You have an opportunity to tell us what we need to do for you
5. Together we can create a strong, united voice to help fight the cause



## Fighting inflammation with food



Inflammation is part of the body's immune response but when out of control – as in PMR and GCA – it can damage the body.

Many people believe that sugary foods and saturated fat can cause over-activity in the immune system, leading to joint pain, fatigue, and damage to blood vessels. There is no clinical evidence yet that anti-inflammatory diets work, but two PMRGCAuk members found that in addition to losing weight, their pain was reduced through avoiding inflammatory foods. Here are their tips:

**Dale Hodgson** battled for two and a half years with PMR flares, weight gain and generally feeling unwell. Then she cut out tea, coffee, alcohol, potatoes, dairy and wheat.

'I've lost the three stone I put on. The end is in sight!'

Dale's Diet includes Redbush, mint, ginger, herbal teas - not fruit – water, coffee substitutes; soya, coconut, rice and oat milks; plenty of green vegetables, salad, beans and lentils, chicken and fish. Red meat only once a

month. Salads comprise of red, purple, green, yellow and orange; wheat free pasta - rice or corn, quinoa, sweet potatoes, millet, barley. Oat cakes are great substitutes for bread.

### Dale's menu

#### BREAKFAST

Home-made green smoothie - green vegetables, chia seeds, raw cacao, berries and a banana.

#### LUNCH

Home-made vegetable/bean soup or salad with pulses, tofu or sardines, wild salmon or mackerel.

#### DINNER

Fish, chicken, pulses with brown basmati rice, quinoa or sweet potatoes and green vegetables

Dale says, 'Eating out is difficult but you can always let the restaurant know in advance your dietary requirements. I have had some chefs really rise to the challenge!'

'I have to be honest - this way of eating needs determination but I am convinced I am where I am today, my pre-PMR size ten, because of my strong will.'

**Penny Denby** was diagnosed with PMR in November 2011. By May 2013 she had put on over three stones in weight. Since cutting out certain foods she has lost 2.5 stones.

Penny cut out: yeast, wheat, dairy and the 'Bella Donna' vegetables plus sugar, coffee and alcohol.

Penny's diet includes – Green tea, coconut, almond or rice milks, green vegetables, sweet potatoes, rice, root vegetables, squash, salad, pulses, quinoa, nuts, chicken, lamb and fish.

### Penny's menu

#### BREAKFAST

Smoothie spinach or kale, grapes, coconut milk and ice or rice puffs, nuts and fruit

#### LUNCH

Rice cakes with hummus and cucumber or home-made soups.

#### DINNER

Fish, chicken, lamb, pulses, brown rice, quinoa, sweet potato, vegetables

Penny says, 'I cook shepherd's pie using sweet potato, rice dishes such as risottos and curries – I avoid tomatoes.'

'Eating out I avoid cream and tomato in sauces. Restaurants often swap potatoes for rice.'

'I stuck absolutely to my diet for two months but occasionally I allow myself a treat such as fries or a dessert when eating out! Sometimes I pay for that with a sleepless night and aching legs!'

**If you would like a copy of Dale and Penny's diet sheets email [northkent@pmrgcauk.com](mailto:northkent@pmrgcauk.com).**

#### WARNING:

These diets worked for Dale and Penny, but it's very important that you always speak to a medical professional who has a good understanding of your health condition before you try any new diet.



## OMERACT 2014

In spring this year I was asked by Dr. Sarah Mackie of Leeds University whether I would be prepared to join her PMR group as a Patient Research Partner at the OMERACT Rheumatology conference in Budapest in May. OMERACT conferences are international, notable for their participative nature, consensus voting and the importance given to patient participation. A quotation from one of their publications gives a flavour of this and shows what I found so attractive.

“We are attempting to develop outcome measures that are clinically relevant – and patient input is at the core of determining what might or might not be clinically relevant.”

The attraction of the concepts was, I am not ashamed to admit, enhanced greatly by the allure of Budapest in May, although at that stage I had not seen the mountain of background reading which would arrive by email nor been told that conference participants worked fourteen hour days with very little time to spend outside our admittedly palatial hotel. Patient Research Partners each had a personalised programme to ensure no one tried to attend too many sessions (which started at 8.30am and ran till 10pm with work continuing through lunchtime and during coffee breaks). Even with this, by the third day two patients were in their beds. Regular meetings each day were held to brief the patient group on forthcoming topics and to report back on our experiences.

Twenty patients with different rheumatological conditions arrived from Canada, the Netherlands, Turkey, USA, Norway and the UK, all feeling nervous, excited and anxious to fulfil the responsibility we felt we had been given to inform others about our experiences and also to represent



When I sent a photo of the view from my window to my four year old granddaughter she said she wanted to join me immediately to “meet all the beautiful princesses who lived in that fairy-tale palace”.

“our illness”. We were encouraged, sometimes even pushed, to contribute to all discussions and voting sessions as full participants so that the patient view was always heard and always counted. 10% of the 200 OMERACT conference participants are always patients, chosen to represent the conditions being discussed that year.

I was part of the PMR Working Group whose presentation was reporting on work done to date and seeking the views of the conference on their choice of the essential measurements to be made when assessing results of clinical trials in PMR. In particular the importance of patients’ and doctors’ fears about steroid- related adverse effects made recording these a candidate for inclusion, with work required on how this should be done.

Throughout the conference, the work put in by all those attending, before during and after workshops and presentations, was incredibly impressive. I would like to think that we, who as patients are sometimes critical of the medical profession and its “lack of interest in PMR”, should be aware just how much work is going on, both in Britain and internationally, on our behalf.

Meeting and talking with other Patient Research Partners was so

interesting. Symptoms such as pain, fatigue and stiffness were common to most, but to see the severity of the impact of conditions such as large vessel vasculitis, myositis and Behcet’s syndrome soon put paid to my depression at having had a major relapse this spring. Unlike some brave and cheerful young ladies I met, I was not forty years old with young children and a condition classed as “life- and organ- threatening”. I had problems with stairs but did not need to carry oxygen cylinders at all times. I felt lucky to have “just” PMR.

I learned so much from my week in Budapest, but what will stay with me longest is the memory of two hundred people, clinicians, researchers, representatives from pharmaceutical companies and patients, all working collaboratively to benefit those of us who are ill with rheumatological conditions.

**LORNA NEILL**



**HELPLINE**

**0300 777 5090**

**[www.pmrangca.org.uk](http://www.pmrangca.org.uk)**

**Registered Scottish Charity No**  
SC037780

**Registered address**  
Forest Lodge, Foulden,  
Berwickshire TD15 1UH



# New Local Support Groups



## FIRST DATE FOR LONDON MEETING

We're delighted to announce the first meeting of our London support group, on Monday 27th October, from 2-5pm at the Artizan Library, 1 Artizan Street, London, E1 7AF – a few minutes' walk from Liverpool Street Station. It is open to anyone with PMR and/or GCA, friends, carers, family members and all those with an interest in finding out more.

The meeting will include Professor Bhaskar Dasgupta as the featured speaker. Professor Dasgupta is one of the leading experts in the field of PMR and GCA, and we are very grateful that he is giving his time to speak. There will be the chance to meet others with PMR and GCA to share experiences and tips for dealing with the many distressing effects of the illnesses.

Please let us know if you would like to attend the first meeting– it would be helpful to know how many people are coming so we know we have enough chairs and refreshments!

The London group will meet quarterly, and we're hoping that as a result we will be able to support volunteers to start additional groups in different areas of the city.

## NEW GROUP IN SHREWSBURY

Another piece of good news for local support is a new group to start in Shrewsbury. As with the London group, it is open to everyone. We are currently gathering details of people who would like to attend, and will then set up the first meeting.

Both groups are a result of the motivation and dedication of our volunteers. We'd like to thank them all.

**To confirm attendance at the London group meeting or find out more about the Shrewsbury group email [Sophy sophy@pmrgcauk.com](mailto:sophy@pmrgcauk.com) or call: 0300 999 5090** (please leave a message if the office is closed. We will respond promptly).

# Support group contacts

The very latest information for all support groups can be found at [www.pmr-gca.org.uk](http://www.pmr-gca.org.uk) including details of speakers and local events. If there isn't a group near to you why not consider starting one – a problem shared is a problem halved! We will help you to get started.

## CAMBRIDGE

**Organiser: Dale Hodgson**  
Phone: 0300 999 5090  
Email: [cambridge@pmrgcauk.com](mailto:cambridge@pmrgcauk.com)

## EAST ANGLIA

**Organiser: Maryan Fidler.**  
Phone: 0300 999 5090  
Email: [eastanglia-pmr-gca@outlook.com](mailto:eastanglia-pmr-gca@outlook.com)

## GREATER LONDON

**New group just started!**  
Phone: Sophy on 0300 999 5090 for more information

## LINCOLN

**Organiser: Rob Murton**  
Phone: 0300 999 5090

## NORTH EAST ASSOCIATE CHARITY

**Organisers: Pam Hildreth & Mavis Smith**  
Phone: 01287 623 334  
E-mail: [pmrgcafightersne@googlemail.com](mailto:pmrgcafightersne@googlemail.com)  
Website: [www.pmr-gca-northeast.org.uk](http://www.pmr-gca-northeast.org.uk)

## NORTH KENT

**Organiser: Penny Denby**  
Phone: 0300 999 5090  
Email: [northkent@pmrgcauk.com](mailto:northkent@pmrgcauk.com)

## MANCHESTER & NORTHWEST

**Organiser: Ann Chambers**  
Phone: 01942 895 806  
Email: [northwest@pmrgcauk.com](mailto:northwest@pmrgcauk.com)  
Website: [www.pmr-gcauk-nw.com](http://www.pmr-gcauk-nw.com)

## PETERBOROUGH

**Organisers: Clare Marshall/Lorna Edmonds**  
Phone: 0300 999 5090  
E-mail: [peterboro@pmrgcauk.com](mailto:peterboro@pmrgcauk.com)

## PLYMOUTH

**Organiser: Sally Ann Morgan**  
Phone: 0300 999 5090  
E-mail: [pmrgca.plymouth@yahoo.co.uk](mailto:pmrgca.plymouth@yahoo.co.uk)

## SCOTLAND ASSOCIATE CHARITY

**Bea Nicholson (Chair)**  
Phone: 0300 777 5090  
E-mail: [info.scotland@pmrandgca.org.uk](mailto:info.scotland@pmrandgca.org.uk)  
Website: [www.pmr-gca.org.uk](http://www.pmr-gca.org.uk)

## SOUTHEND/ESSEX

**Organiser: Hannah Padbury**  
Phone: 01702 587 436  
E-mail: [southend@pmrgcauk.com](mailto:southend@pmrgcauk.com)

## TAUNTON

**Organiser: Wendy Morrison**  
Phone: 0300 999 5090  
E-mail: [pmrgca.southwest@yahoo.co.uk](mailto:pmrgca.southwest@yahoo.co.uk)

## SURREY

**Organiser: Shirley O'Connell**  
Phone: 0300 999 5090  
Email: [surrey@pmrgcauk.com](mailto:surrey@pmrgcauk.com)

## SUSSEX/SOUTH COAST

**Organisers: Christine Young & Catherine Pickersgill**  
Phone: 0300 999 5090  
Email: [pmrgcasouthcoast@btinternet.com](mailto:pmrgcasouthcoast@btinternet.com)