

Return To Categories Clinical Topics Advanced Pain Management with Russell Portenoy, MD; Community Based Palliative Care with Martha Twaddle, MD.

Flam, Norway - Cruise Sognefjord, King of the Fjords, and take a thrilling, cliff-hanger train ride from sea level to the lofty mountain heights above. Villages and terraced farms perch on the slopes above dramatic waterways. Currently, there are no shore excursions available in Flam, Norway. Kristiansand, Norway - Kristiansand is the largest city in Southern Norway. Kristiansand is a family destinations, focusing in activities and attractions for families, one of the largest is Dyreparken, a gigantic zoo and amusement park which celebrates its 50th anniversary in Watch the changing of the palace guard. Ferry to the open-air Folke Museum with its 12th-century stave church. Cruise Lysefjord to sail under Prekestolen Pulpit Rock , a huge cube that looms feet above your boat. Our staff can assist you with all your travel arrangements. Call us at We can assist you with all your travel arrangements. All conferees, their families, and guests must book their cruise within the CEI meeting group through Continuing Education, Inc. This ensures our company can provide conference services and complimentary social amenities to all meeting participants and their guests. Thank you for your cooperation. Our interior designer, guided by guest feedback, was given the freedom to completely reimagine staterooms aboard. A very special amenity exclusively for guests cruising in a Neptune or Pinnacle Suite, the industry-leading Neptune Lounge features a private place to relax, socialize with other suite guests and enjoy the personalized service of a concierge. The fleet-wide lounges provide worktables, large screen television, library, sofas and chairs, and refreshments throughout the day. Pinnacle Suite Floor-Plan Please call for best pricing. Neptune Suites SA " Step into a private haven characterized by light, space and elegance. Neptune Suite amenities include: Please call for best pricing. Signature Suite SS Step into a private haven characterized by light, space and elegance. Vista Suite A Step into a private haven characterized by light, space and elegance. Spa Verandah Step into a private haven characterized by light, space and elegance. Veranda VD - Step into a private haven characterized by light, space and elegance. OceanView Stateroom E - Step into a private haven characterized by light, space and elegance. Inside Stateroom J - Step into a private haven characterized by light, space and elegance. Prices are Per Person based on Double Occupancy. Prices are subject to change. Please check with one of our cruise consultant for policies applicable to this cruise Important Note: Appropriate symbols within the rooms on the deck plans describe differences from the stateroom descriptions. All information is subject to change. Although subject to change at any time, the listed prices are generally available up to about 90 days before sailing; at that time they convert to typically higher, market rates. Rates offered directly by the cruise line and quoted by our agents are also subject to change at any time, can be withdrawn at any time and are capacity controlled. Cancellation policies vary by cruise line, itinerary and length of cruise. When reserving your stateroom, please review the policy applicable to this cruise with our staff. We strongly recommend Travel Insurance to cover the unexpected. Cruiselines may implement a fuel surcharge depending on the price of crude oil. Cruise Line cancellation policies are strictly enforced. For that reason, we urge all of our travelers to carefully consider whether travel insurance is a good value for them. Certainly, if you have reason to think that "something might come up" that might force you to cancel, travel insurance is worth the cost of the premium. If travel insurance is the right choice for you, we recommend TravelSafe. To visit their site and explore your options click here or on the link above.

2: Topics in Palliative Care - Russell K. Portenoy; Eduardo Bruera - Oxford University Press

The appearance of Topics in Palliative Care meets the growing need for information in this rapidly evolving field. This first volume in this series concentrates in four crucial areas: pharmacotherapy of pain, psychosocial adjustment to cancer, management of delirium, and gastrointestinal disorders.

Can we use those topics to determine CMS interest in hospice scrutiny? What are the concerns with live discharges and how can a hospice monitor live discharges to be aware of triggers for scrutiny? Is GIP utilization still an interest? Hear the latest hospice medical director issues and how your hospice can ensure compliance. And finally, what is the latest with hospice quality reporting and Hospice Compare. Webinar Objectives At the completion of this Webinar, participants will be able to: Judi serves as a key contact with the Centers for Medicare and Medicaid Services, interfacing with hospice payment policy, Part D, survey and certification, contractor management, and program integrity functions, among others. She also represents hospice and palliative care with the Medicare Administrative Contractors and other federal agencies and many national organizations. She is a frequent speaker at state and national meetings and works daily with hospice providers and state hospice organizations on the ever-increasing array of regulatory and compliance issues. She works with her team at NHPCO to develop regulatory and compliance tools, including hospice payment rates and wage index values and compliance guides. She is also a certified compliance professional CHC. Carol has many years of experience as a hospice nurse. She served on the National Board for Certification of Hospice and Palliative Nurses for six years and is past chair of the Examination Development Committee for the certification examination for advanced practice hospice and palliative nurses. Spence has experience in research design, and in developing, implementing and managing field research projects. She holds a doctoral degree from the University of Maryland School of Nursing and a Master of Science degree in mental health nursing. NHPCO designates this live activity for a maximum of 1 contact hours. Nurses should claim only the contact hours commensurate with the extent of their participation in the activity. Accredited status by ANCC refers only to continuing nursing education and does not imply endorsement of any commercial product discussed in conjunction with this activity. The National Hospice and Palliative Care Organization is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Physicians should claim only the credit commensurate with the extent of their participation in the activity. Certificate of Participation for Non-physician Healthcare Professionals:

3: Hospice Vs. Palliative Care

Topics of Interest. CAPC ensures access to the training, technical assistance and metrics needed to address the major palliative care topics of the day.

Palliative Care The differences between hospice and palliative care. Hospice care and palliative care are very similar when it comes to the most important issue for dying people: Most people have heard of hospice care and have a general idea of what services hospice provides. Where palliative care programs and hospice care programs differ greatly is in the care location, timing, payment, and eligibility for services. Place Hospice Hospice programs far outnumber palliative care programs. Hospice often relies upon the family caregiver, as well as a visiting hospice nurse. While hospice can provide round-the-clock care in a nursing home, a specially equipped hospice facility, or, on occasion, in a hospital, this is not the norm. Palliative Care Palliative care teams are made up of doctors, nurses, and other professional medical caregivers, often at the facility where a patient will first receive treatment. These individuals will administer or oversee most of the ongoing comfort-care patients receive. While palliative care can be administered in the home, it is most common to receive palliative care in an institution such as a hospital, extended care facility, or nursing home that is associated with a palliative care team. **Timing Hospice** You must generally be considered to be terminal or within six months of death to be eligible for most hospice programs or to receive hospice benefits from your insurance. **Palliative Care** There are no time restrictions. Palliative care can be received by patients at any time, at any stage of illness whether it be terminal or not. **Payment Hospice** Before considering hospice, it is important to check on policy limits for payment. While hospice can be considered an all-inclusive treatment in terms of payment hospice programs cover almost all expenses insurance coverage for hospice can vary. Some hospice programs offer subsidized care for the economically disadvantaged, or for patients not covered under their own insurance. Many hospice programs are covered under Medicare. **Palliative Care** Since this service will generally be administered through your hospital or regular medical provider, it is likely that it is covered by your regular medical insurance. It is important to note, however, that each item will be billed separately, just as they are with regular hospital and doctor visits. If you receive outpatient palliative care, prescriptions will be billed separately and are only covered as provided by your regular insurance. In-patient care however, often does cover prescription charges. For more details, check with your insurance company, doctor, or hospital administration. **Treatment Hospice** Most programs concentrate on comfort rather than aggressive disease abatement. By electing to forego extensive life-prolonging treatment, hospice patients can concentrate on getting the most out of the time they have left, without some of the negative side-effects that life prolonging treatments can have. Most hospice patients can achieve a level of comfort that allows them to concentrate on the emotional and practical issues of dying. **Palliative Care** Since there are no time limits on when you can receive palliative care, it acts to fill the gap for patients who want and need comfort at any stage of any disease, whether terminal or chronic. In a palliative care program, there is no expectation that life-prolonging therapies will be avoided. It is important to note, however, that there will be exceptions to the general precepts outlined. There are some hospice programs that will provide life-prolonging treatments, and there are some palliative care programs that concentrate mostly on end-of-life care. Consult your physician or care-administrator for the best service for you. For additional caregiving information, visit www.

4: How to Plan Research in Palliative Care

By: CVH Team What is palliative care?. Palliative care is a type of health care for patients and families facing life-limiting illness. Palliative care helps patients to achieve the best possible quality of life right up until the end of life.

Santosh K Chaturvedi; E-mail: Abstract Research in palliative care has its challenges. However, research in different aspects of palliative care is important. This paper gives simple methods of planning and conducting a research in the area of palliative care in India. Palliative care is a relatively new field, especially in India, and requires much active researches to give us knowledge based on local settings and environment. The research or study may be done as an academic requirement for the educational course as a thesis or dissertation, or for individual interest, or through funding opportunity. It may be done for making a presentation at a conference and overall for career growth. The research should be a systematic investigation or evaluation, done with a clear purpose or objective, based on observable experience in an unbiased way, leading to the possible or probable answer to the investigative question. The research should be such that is of benefit or definite implications like either adding to existing knowledge, providing better understanding of a phenomenon, or a new finding or intervention. The first step is identifying the area on which a researcher wants to do a study. In palliative care, common broad areas can be related to: Pain and pain relief Other symptoms like fatigue, lymphoedema, delirium, nausea, cachexia, etc Psychological issues like depression, demoralization, phobias, anxiety, panic Social factors like social stresses, social support, family issues Communication issues like collusion, difficult questions Interventions-pharmacological or non-pharmacological, complementary methods Staff stress and burnout Systematic reviews and meta analysis Grief and bereavement Once the area is identified, the researcher should ask a research question to himself or herself. This is perhaps the most important initial decision to be made, as once this is decided, the objectives, hypotheses, and methodology can be planned. This should arise as a curiosity for the researcher. First, to know about what is already known about the theme one wants to pursue? Second, to know about other studies that had pursued the area, and what were their limitations, and plan a study overcoming those limitations. The literature search should be thorough, after consulting relevant books, journals, internet sources and search engines. It is useful to discuss with the supervisor, guide or someone who has already done similar work. If this is a question, it could be like-What is the severity of cancer pain at the time of admission into a hospice or palliative care setting; what is the nature and prevalence of anxiety, worries, depression, demoralization, in a palliative care centre; how does grief manifest among the relatives of the cancer patient; when does the nausea increase or decrease; how to measure fatigue in terminal stages; why does one get staff stress and burnout. The research question could be-what, why, when, where, why, how, how much, etc. When the aim is a statement, it could be like-to study the clinical and demographic factors related to terminal delirium or to study the efficacy of newer analgesic in the management of cancer pain, to understand the development of stress among palliative care professionals. The aim should be as specific as possible, which would make it easier to plan out an appropriate methodology for the study. The objectives basically split the aims into specific parts of the main aim. One needs to think over, the method to get an answer or information for the main aims and objectives laid down. Think of ways in which the answer to the research question could be sought and the advantages or limitations of each method. If needed, a Pilot phase of the study can be conducted to evaluate the feasibility of the study, time taken per subject, and any difficulties encountered. The research methodology indicates the type of the study. The studies could be Qualitative or quantitative Qualitative studies look at detailed accounts of an experience or phenomenon, and may ask broad, open ended, interconnected questions, the answers of which give insights into the event, rather than counting number of subjects with the experience. These are based on detailed interviews, focus groups, case studies, guided interviews, and knowledge attitude behavior patterns studies. The results are in the form of transcripts and verbatim accounts. Qualitative methods are often used in unstudied or understudied areas and may lead to a quantitative study and vice versa. Quantitative studies are the traditional studies with a number of subjects which are analyzed to give patterns of differences in numbers, rather than actual experiences. Descriptive or comparative Descriptive studies tend to examine the features of

a phenomenon and its description, whereas the comparative study compares these observations with another group of patients with similar problems or a normal healthy control group. Retrospective or prospective or cross-sectional study A cross-sectional study provides information about the situation that exists at a single point of time. These could be on disease or symptom description or process. A longitudinal study provides data about events or changes during a period of time, it may be retrospective-if previously recorded data or observations made before the start of study is used, or prospective- if data is recorded or observations are made after the start of study. Prospective and retrospective studies may be on an intervention or on observations. Open studies or blind studies In open studies, the subjects and researchers are aware of the intervention and who is getting it. In single blind study, either the subject or the researcher is not aware of the intervention; in double blind, both the subject and the rater are unaware about the intervention and who is getting it or not. Blinding is done to remove rater or subject bias. Randomized controlled trials or double blind placebo controlled trials are considered a stringent method as it removes many biases. The subjects are selected using random methods, and the study has a control group of other intervention or a placebo, and both the subject and rater are unaware of the intervention details. Follow up studies are when a group of subjects are called back to study any changes in their condition after a period of time. Cohort studies include a group of subjects who are observed periodically till the end of the study. Case controlled studies are studies done where each case is compared with a control subject of similar characteristics. Depending on the nature of study and the aims and objectives, the sample size needs to be decided. The source of sample also needs to be identified, whether the sample would be from general population, out patients, admitted patients, hospice, community care centre, from staff, relatives or caregivers. The study period also needs to be fixed in terms of days, weeks or months, or any prespecified period. The sample should be adequate, representative, and unbiased. The inclusion and exclusion criteria can be fixed to study the sample which needs to be studied and exclude unwanted or undesirable sample. Sample size needs to be adequate for the study and varies between the types of the studies. It may be a few persons in a qualitative study or a large population depending on whether it is a descriptive study or intervention related. There are many ways of calculating the sample size, and the power of sample size can be derived which would make the findings reliable and valid. It is better to consult a statistician to do the power calculation and get advice on the adequate and appropriate sample size. Identify variables to be studied. These should be related to the aims and objectives of the study. There may be a need to develop operational guidelines. Scales or instruments or measures: Identify scales or instruments which will be helpful in seeking the answer to the research question. Choose standard measures, which are reliable, valid and have good psychometric properties, and preferably those which have been translated, adapted, and used in the Indian setting. This should start with seeking informed consent and explaining the purpose of the study. Information should be collected in an unbiased way. If an intervention is involved, this should be done in a standard way. Nobody who does not consent need be included in the study. Statistical analysis The data needs to be cleaned for inconsistency, inaccuracies and missing data handling. The data can be entered into a statistical package like SPSS or on an excel sheet. The statistics could be simple description of subjects with percentages, mean, median, standard deviation. If comparisons are made comparative statistics like chi-square or t-test can be used. Multivariate and other relevant statistics can be employed in discussion with the statistician. The levels of statistical significances or lack of this should be clearly mentioned. RESULTS These should be presented in neat simple tables which are self-explanatory and the important observations should be written in text as well. Are the findings comparable to those of other similar studies? If not, why not? The discussion should provide an interpretation of the findings. Limitations There is no harm in acknowledging the limitations of the study, as all studies are bound to have some limitation or the other. Future directions It is a good idea to give suggestions for overcoming limitations of the study, and indicate how the findings are heuristic and lead to further studies. CONCLUSION The main observations should clearly indicate the conclusion, which is like the final answer to the question raised as the aim, even if, the answer is negative, incomplete, or inconclusive. Summary A summary with the statement of aim, methods, main findings, interpretation, and conclusion makes a easy source for a reader to decide whether the complete report needs to be read or not. These are usually dictated by the Institute or the journal. The references should be complete,

and one should cross-check their accuracy. Writing up thesis, dissertation, report, or paper: This is the final outcome of the study. The study completion may end up as a bound thesis or dissertation, or submitting the paper for publication in a peer reviewed journal. The findings can also be presented at any scientific conference. Always have a written research protocol which should be followed strictly without any variation. It is good to have views and suggestions of peer, teachers, and supervisors, which might help in overcoming any blind spots in the researchers. Research done with interest and passion is always a joy! Footnotes Source of Support: Nil Conflict of Interest:

5: Palliative Care: MedlinePlus

This is the fourth book in a series devoted to research and practice in palliative care. This rapidly evolving field focuses on the management of phenomena that produce discomfort and undermine the quality of life of patients with incurable medical disorders.

See Article History Palliative care, form of health care that seeks to improve the quality of life of patients with terminal disease through the prevention and relief of suffering. It is facilitated by the early identification of life-threatening disease and by the treatment of pain and disease-associated problems, including those that are physical, psychological, social, or spiritual in nature. As defined, palliative care begins at the point of diagnosis of terminal disease and can be delivered in a variety of health care settings. In general, it involves health and social care professionals working in hospitals, communities, hospices, and voluntary sectors. Palliative care has been associated with many different terms, including terminal care, care of the dying, end-of-life care, and supportive care. However, these forms of care are not necessarily the same as palliative care. Likewise, palliative care is also sometimes described as hospice care. While hospice care does imply palliative care, it is specific to care provided near the end of life see below Hospice care. Principles of palliative care Palliative care emphasizes three main principles: It is also a necessary component in meeting the physical and psychosocial needs of the patient and his or her family. Symptom management is needed in order to help patients live life to the fullest until they die. Types of palliative care The concept of offering medical care for the dying within a setting organized for that purpose emerged in Dublin in the late 19th century and was established in England early in the following century. The founding of the palliative care movement, however, is widely attributed to Dame Cicely Saunders, a British physician and humanitarian who pioneered the palliative care approach with the opening of St. In the United Kingdom it took a further two decades for palliative care to be recognized as a medical speciality, and in the United States it was not accepted as a medical discipline until Its acceptance as an area of medicine led to numerous advances in its delivery and to changes in its organization as a system of care. As a result, palliative care has been subdivided into general and specialist palliative care. General palliative care General palliative care is based on the three guiding principles of palliative care and is a core skill of nurses and doctors. Specialist palliative care Specialists in palliative care deliver care for patients with complex needs. Specialist palliative care teams are multidisciplinary, being composed of nurses, doctors, allied health and social care professionals, religious leaders, and individuals from the voluntary sector. Specialists may be based in a hospice or may be part of a specialist team at a hospital. They work either directly with patients and families or with other health care professionals to complement the general care that the patient receives. Indeed, the first hospice facility in Dublin was established by a group of Irish nuns known as the Sisters of Charity. Today hospice facilities provide a variety of services, including specialist and community palliative care. Hospice inpatient units were initially established to deal with the needs of patients suffering from terminal cancer. Hospice services increasingly have been sought from patients with other terminal illnesses, such as amyotrophic lateral sclerosis ALS; motor neuron disease. Patients are admitted to inpatient hospice care for a variety of reasons, including assessment, rehabilitation, pain and symptom management, and short respite stays or terminal care. Families are encouraged to be involved in care where appropriate, and visiting tends to be open. Staff normally have access to specialized training and education in palliative care. Community palliative care teams A community palliative care team may consist of specialist palliative care nurses who visit patients and families in their own homes or who are part of a larger team that delivers care to patients in facilities such as hospices or hospitals. In the early 21st century, hospital and community palliative care nurses began to work more closely together, often crossing the boundaries that traditionally separated hospital and community care. The role of the community palliative care team includes providing support and advice on pain and other distressing symptoms, providing emotional support for the patient and their families, and providing bereavement support. Charities have led the way in providing community-based support by providing nursing services. Developments in palliative care Palliative care is a global concern, and a steady rise in the number of people

who are living longer with degenerative disease suggests that demand for palliative care services will increase in the 21st century. As a result, advancing and improving palliative care are areas of intense interest. The Liverpool Care Pathway is used by health care professionals to plan interventions in the last stages and hours of life and is intended to help guide decisions about appropriate interventions and treatments, both physical and psychosocial. The needs of the patient and family are central to this pathway. In some places, palliative care standards are incorporated into a larger system of care. For example, the Gold Standards Framework offers guidance to primary health care teams and has identified tasks that help improve end-of-life care in the community. Its principles reflect those of WHO and include symptom control, effective communication, coordination and continuity in services, support and care of the dying and their families, and continued learning for staff.

6: Hot Topics in Palliative Care - Hospice Action Network

Palliative Care: A Multidisciplinary Approach. Hospitalists are often the providers who support patients and help their families navigate their serious illness, focusing on providing palliative care to manage the pain and stress of that illness, which is a delicate process.

CVH Team What is palliative care? Palliative care is a type of health care for patients and families facing life-limiting illness. Palliative care helps patients to achieve the best possible quality of life right up until the end of life. Palliative care is sometimes considered end-of-life care, with a main focus on comfort. However, it is increasingly recognized that a palliative approach, as part of health care is beneficial early on in serious and chronic illness. In Canada and around the world, quality palliative care: Palliative care does not necessarily end when someone has died. Family members may need support as they grieve the loss of a loved one and try to manage numerous strains and stresses. Bereavement programs are often part of the comprehensive care offered as part of palliative care. Palliative care can be provided at any time, to anyone with advanced illness, regardless of age. A more difficult question is knowing when the time is right to actually become registered with a palliative care program. Many palliative care programs will not register patients who are in the early stages of illness. As long as your health care providers are paying close attention to controlling your pain and other symptoms, you are receiving palliative care. Who provides palliative care? Many health care providers contribute to palliative care teams, depending on the needs of the patient and the family. Canada does not have a national palliative care program, so you may see differences in the type of care available in each province. The people contributing to your care will also vary depending on your specific needs and the services available where you live. Where is palliative care provided? Palliative care can be provided anywhere. Many palliative care programs provide services and support for patients wherever they are living – at home, in a residential hospice, in hospital or in a personal care home. The best place to receive care is usually the place that best matches your needs. Home Some people choose to stay at home for as long as they can. Family members, with support from the health care team, may decide that they want to be the main caregivers in the home. Many communities have supports in place and services to help patients and families provide care at home, including these: Respite programs Family caregivers need time to rest and many home care programs offer respite programs that provide short-term patient care for several hours or even several days. Home care programs Most Canadian home care programs offer palliative care services in the home. Professional nursing care is often available through these programs, along with other home-based support services. Private companies Sometimes people will pay for private home care services because they need extra help. Private home care companies supply part-time, as needed or around-the-clock care. However, unless you have insurance, you will have to pay for these costs yourself. Private services may include:

7: Topics “ What Is Palliative Care? ” Canadian Virtual Hospice

Topics Related. Health, Health Care, and Aging; Hospice Care; Researcher Spotlight. Sangeeta C. Ahluwalia Senior Policy Researcher. Sangeeta Ahluwalia is a health services researcher at the RAND Corporation and assistant professor at the UCLA Fielding School of Public Health.

Palliative Care What it is Palliative care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems. Palliative care is an important means of relieving symptoms that result in undue suffering and frequent visits to the hospital or clinic. At the community level, lack of palliative care places an unnecessary burden on hospital or clinic resources. How it is done Deciding who is to provide palliative care Health workers: Health workers can provide basic medical and psychological support including necessary drugs to control pain and other symptoms that occur as a result of HIV related disease. Family and community caregivers: Friends, relatives and others in the community can be trained to ensure that the patient is comfortable. Medical attention from health facility workers home visits to support the patient and to assist the caregiver should be available as needed. Families and friends should be provided support even after the death of the patient. Bereavement counselling is an opportunity to support the loss of affected loved ones and to consider future plans. Deciding where palliative care can be provided In low HIV seroprevalence countries palliative care may be a routine part of hospital and clinic care. In countries with a high burden of HIV infection, palliative care should be part of a comprehensive care and support package, which can be provided in hospitals and clinics or at home by caregivers and relatives. In many settings, HIV infected people prefer to receive care at home. The provision of palliative care can be augmented significantly by the involvement of family and community caregivers. A mix of psychosocial support, traditional or local remedies, and medicines can be combined to provide palliative care that surpasses that found in many overcrowded or poorly staffed hospitals. Wherever palliative care is provided, factors to be assessed include affordability and the presence of community care and support services. Training on the provision of palliative care should be incorporated into the curriculum for all health care providers. Guidelines for home care services should include basic management of palliative care by family members and community volunteers. Training courses for family members and community volunteers can be organised and provided by health care workers at the community level. In all of the above, symptomatic care and pain control using the full analgesic ladder should be incorporated.

8: Hot Topics | National Hospice and Palliative Care Organization

Research in palliative care has its challenges. However, research in different aspects of palliative care is important. This paper gives simple methods of planning and conducting a research in the area of palliative care in India. Research is important in any area of science, health, and medicine to.

9: WHO | Palliative Care

Palliative care consultations that focus on improving overall quality of life, managing pain, and defining goals of care at the outset of therapy for patients with serious life-threatening illness can result in shorter hospital stays and lower costs.

The Septuagint behind the New Testament The lasting joy that is Jerusalem Meditation in the Chiri Hills (Chung Yu-Chang) Criminal Law Review-1996 (Criminal Law Review, 1996) I wanted the elevator, but I got the shaft Sharons surprise Budget imbalance and the external influences: A study for the Legislative Budget Board of Texas Evidence of geometry in Indus Valley civilization, 2500-1500 B.C. Human learning orrmrod 6th edition The unborn baby book Norman geras marx and human nature Tutoring and mentoring Imam al haddad book of assistance Community Work in the Uk 1982-86 A lawyers basic guide to secured transactions Dinosaur design Barry Curtis Organizing for reproductive control Outrageous claim #3 : you can survive the rat race without becoming a rat Vi and vim editors pocket reference 2nd edition Burmese-English dictionary Subtracting Fears for the Future Black Resistance Movements in the United States and Africa, 1800-1993 Millennium Development Goals And Migration My uments have on the end Painting a new world The True Story of the Three Little Pigs by A. Wolf Writing paper with border The published writings of Isaac Lea, LL. D. Rainbow connection piano sheet music lower key To err is human Canadian Politics For Dummies Static timing analysis for nanometer designs Certified associate in project management book Thoughts and their subject Art and homosexuality a history of ideas Comparing companies Normal surface anatomy Entries, 1870-1879 Head direction cells and the neural mechansims of spatial orientation A practical directory for young Christian females