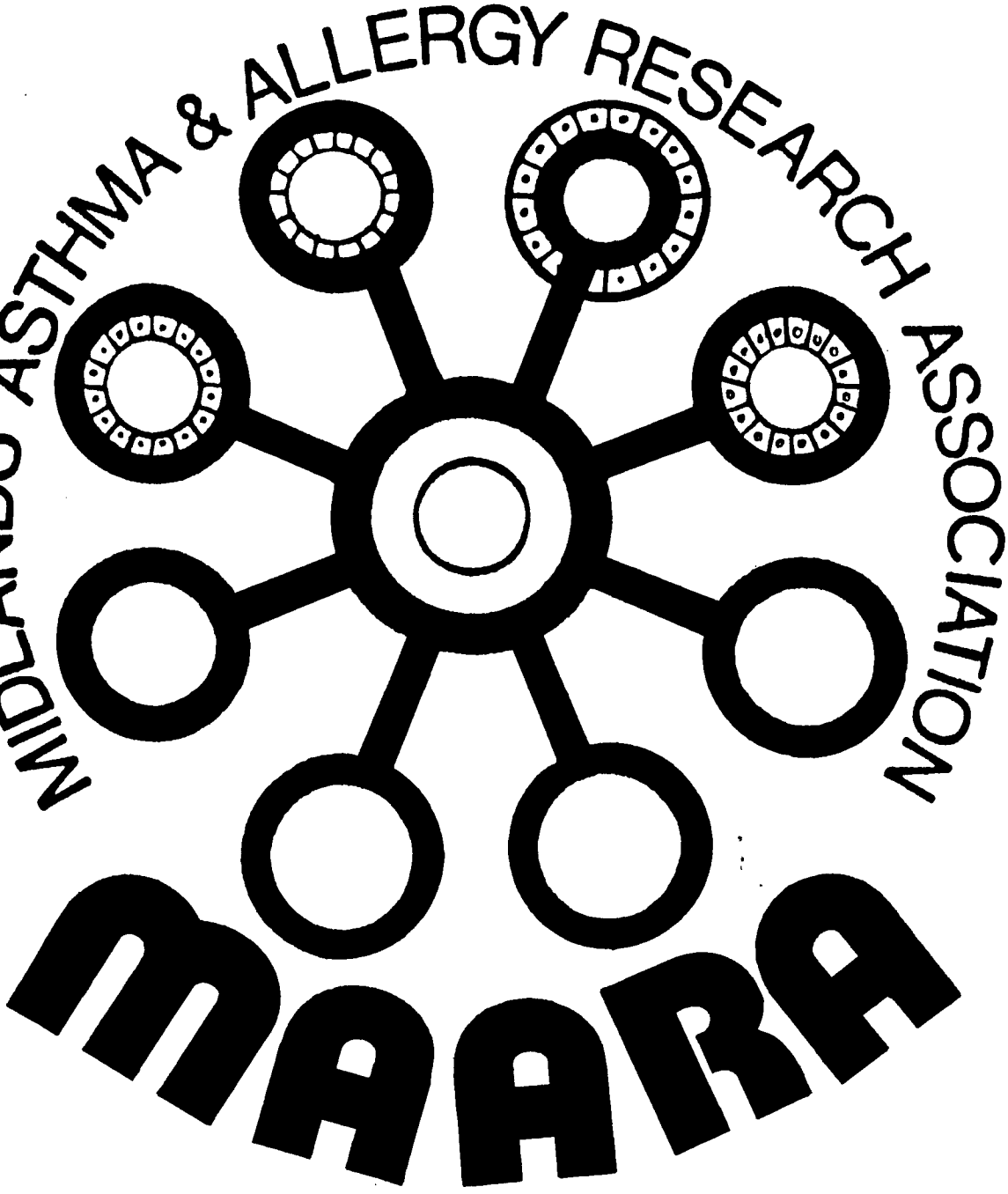
1988

NEWSLETTER



MAARA
Registered as Charity No. 257131
under the Charities Act 1960

THE MIDLANDS ASTHMA AND ALLERGY RESEARCH ASSOCIATION
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Farouk Shakib, Ph.D	Head of Immunology Research
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Marie Price, RSA Dip.	Medical Secretary
David Edwards, C.Eng., M.I.Mech.E., Prod.E., FIMS	Appeals Organiser
Julie Cordon, B.Sc.	Aerobiologist
Wendy Millington, B.Sc.	Aerobiologist

Spring 1988

Dear Members,

Thank you for your continued support. MAARA has had an interesting year but not a financially rewarding one. This is causing considerable concern to our research laboratory who are not only desperate for funds to continue their present projects but are also having to shelve promising important investigations which they had planned to commence in the new year. To help alleviate this situation it has been decided to commercialise the routine work of the laboratory. The press release announcing this new venture appears on page 22 of this newsletter.

It is with considerable sadness that we report the retirement of our Chairman, Dr M C S Kennedy, our Hon. Secretary, Mr Brian J Shingleton and our Hon. Treasurer, Mr Harold Statham. All have been totally dedicated to the aims of MAARA, Mr Shingleton and Mr Statham being founder members in 1968. MAARA would not be the success it is today without their guidance, their unceasing loyalty and their very hard work. We shall miss each one of them sorely.

However, not all is doom and gloom. Spring sees us full of optimism. We are delighted to announce that Councillor Richard Keene has accepted the Chairmanship of MAARA. We are already indebted to him for substantial donations and lots of publicity in his Mayoral year so we are doubly honoured that he should wish to continue helping us in such a practical way. We look forward to his leadership.

We are also very pleased to welcome Mr Peter Carlin, a Derby solicitor, to the position of Hon. Secretary and Mr Brian Strafford, a Derby bank manager, as Hon. Treasurer. We hope they will enjoy the challenge that working with MAARA always sets, for many years to come.

Last, but by no means least, our spirits have been lifted by the arrival of David Edwards who is trying very hard to alleviate the symptoms of allergic disease by raising funds for research. He would be delighted to hear from members who would be willing to help him in his various projects.

Ann Harries

FUND RAISING NEWS

I joined MAARA last December, excited at the prospect of relieving kindly individuals and benevolent companies of their money in the interests of a worthwhile cause. What could be simpler, or more fun?

Well, here I am, having come back down to earth, slightly frustrated but also a little wiser. There is, after all, no Father Christmas!

Appeal letters have been sent to about 100 charitable trusts and like bodies with, so far, wholly negative results. A similar number of appeals have been made to supposedly top "giving" companies, with a very modest response. I suppose that with the volume of mail these organisations receive, one should be grateful for an answer, even if it is NO. Clearly, with around one quarter of a million charities all claiming that their cause is more worthy of support than the next, it would be too much to expect the ride to be smooth. It certainly appears that there are more emotive causes around which derive benefit from "fear" and from extensive media support together with good marketing over past years.

So, where do we go from here?

I believe image building and publicity to be high priority. The awareness level amongst the general public concerning the effects of asthma and allergies seems to me to be low. Too few people are aware of the role and potential of MAARA. These problems must be addressed.

Fund-raiser for MAARA

THE Derby-based Midlands Asthma and Allergy Research Association, which desperately needs finance to continue its work, has appointed Mr David Edwards, of Duffield, as part-time fund-raiser.

Mr Edwards, a retired chartered engineer, is hoping to encourage industry and commerce to support the charity which sponsors a research and treatment centre in Vernon Street.

At present much of the money for research comes from small donations from the public and local organisations.

Mr Edwards was management services officer with Derbyshire County Council until his early retirement last year. He is secretary of the Duffield Club, and a former captain of Chevin Golf Club.

Meanwhile, whilst mail shots will continue to have a place, we must simply concentrate on basics. An impressive amount of effort is put in already by many small groups and individuals through their whist drives, sponsored walks and the like, which hopefully will continue. Dare I ask for more - emphatically YES. MAARA is finding money increasingly difficult to obtain.

We must endeavour to step up the frequency and level of events which will offer something in return for contributions, but this requires ideas and many pairs of hands. Please offer both - no reasonable offer will be refused!

I have a number of activities, in various stages of organisation, which should generate funds. For your information, these are:

MARCH - leaflet drop through Derby Trader network. Pilot scheme to include Duffield, Quarndon, Darley Abbey and Allestree.

APRIL - Lecture on a Management subject at the Clovelly Hotel.

23 APRIL - Turnstile collection at Derby FC Ground.

APRIL - Charity golf competition at Chevin Golf Club.

19 JUNE - Home fare stall and tombola at Fire Service Gala at Markeaton Park.

AUGUST - Ex-Derby County All Stars Football Match.

SEPTEMBER - Fashion Show.

SEPTEMBER - Male Voice Choir - Assembly Rooms, Derby.

DECEMBER - Raffle.

I would like to include an auction somewhere - perhaps October, if not sooner, and for this purpose I would like as many readers as are able to find us some marketable objects which might raise a few pounds at such an event. As soon as possible please, so that we can start organising.

Also, if you have any articles (preferably new and unused) or can persuade local businesses to donate products suitable for the Tombola at Markeaton Park or the December raffle - please act NOW.

Whilst on the subject, some goodies or craft products for the home produce stall at the Fire Service Gala would be very welcome, as would a few volunteers to staff the stall for an hour or two during the day. Give me a ring if you can help.

With luck maybe we should be able to report favourably in the next newsletter, but until then, keep spreading the word - MAARA - send in your ideas and do keep up your local fund raising efforts.

David Edwards

BIG-hearted students at Derby College of Higher Education raised £600 for charity during Rag Week.

Pictured at the presentation at the Mayor's Parlour in Derby are (from left) David Edwards of the Midlands Asthma and Allergy Research Association; Sally Maws, Rag committee treasurer; David of the Derby Samaritans, Derby's Mayor Councillor Nancy Wawman; Councillor Richard Keene, chairman of MAARA; Helen Walker, students Rag Week publicity officer; Kate Yates of the RSPCA and Margaret Henry, president of Derbyshire Red Cross.

Good Start David!

YOUNG Samantha Riley suffers from asthma — but that didn't deter her from running more than four miles in a marathon to raise money for charity.

The 15-year-old from Kilburn competed in the Chellaston half-marathon and raised £85 for the Midlands Asthma Allergy Research Association, which she presented to its principal, Dr Harry Morrow Brown, at the Vernon Street clinic.

Ian raised £287.63.

Good Sports!

MARATHON man Ian Cooper has won the support of fellow asthma sufferer MP Mrs Edwina Currie in his latest fund-raising bid.

Mr Cooper (34) is being sponsored at 10p a mile by South Derbyshire's Mrs Currie in the London Marathon on Sunday. He is raising money for the Midlands' Asthma and Allergy Research Association in Derby.

"I was running through Findern as part of my training programme when I bumped into Edwina," said Mr Cooper.

"We exchanged greetings and went our separate ways. But when I found out she was an asthma sufferer I decided to write to her at the House of Commons and ask her to sponsor me.

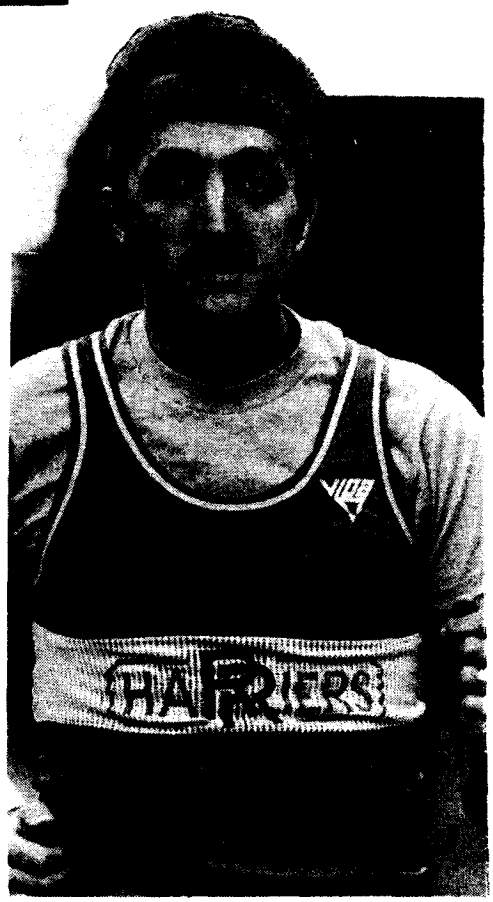
"I got a very nice letter back saying she would," said Mr Cooper, of 24 Birchwood Avenue, Littleover, Derby.

Trouble

Mr Cooper, a senior occupational health nursing officer at Rolls-Royce and Associates Limited in Derby, has been an asthmatic all his life.

His launch into the marathon world started in 1983.

"A friend and I decided to start training and enter for the Derby Ramathon in 1984. We gave ourselves a year's training and I took it slowly because of the asthma."



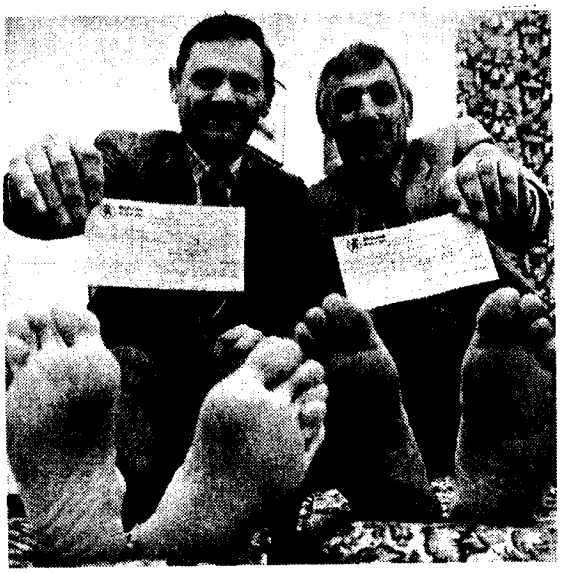
● **IN TRAINING: Ian Cooper gets support from fellow asthma sufferer Mrs Edwina Currie.**

JOHN O'GROATS TO LANDS END - FOR MAARA!

In October 1987 I had the very pleasant task of travelling to Leeds for a presentation ceremony at St. Gemma's Hospice to be presented with a cheque for - wait for it! - £5,500. A similar cheque was also presented to the Hospice to help them continue with their marvellous work.

Derek Mason (53) and Tony Minchella (46), both grandfathers, undertook a sponsored walk in June 1987, covering an average 30 - 35 miles a day on their marathon walk from John O'Groats to Lands End, approx. 1,000 miles. They are both from Bradford and are well known in that area for their continuous work for charity. Their walk took them through Leeds and there they were greeted at St. Gemma's Hospice with a hot meal and a very welcome chance to have a soothing soak for their aching feet.

Unfortunately, Derek's son died aged 13 after an asthma attack, so he had a very valid reason for raising money to help with research into the treatment of asthma, and we hope that our work here will justify his very hard work in raising this wonderful sum for us. A short time later, we received a further cheque for £30, bringing their total donation to £5,530. As this is one of the largest single donations we have ever received, we are truly grateful to this energetic pair of gentlemen for this wonderful gesture.



What a feat

Evelyn McGibbon

We are sorry to say 'goodbye' to the author of this article, Evelyn. She has been a medical secretary with MAARA for 4½ years and she will be sorely missed for her professionalism and her genuine concern for MAARA. Every member of staff here is sorry that she is leaving but as she will be working only a stone's throw away on Friargate, we are sure to see her cheery face once in a while.

Congratulations, Evelyn, on your new appointment and good luck for the future.

PLEASE SPONSOR A CHILD

HIGH ALTITUDE TREATMENT FOR CHILDHOOD ASTHMA

Asthma has become more and more common in the past 20 years, now affecting at least one child in ten. Yet asthma is often unrecognised and untreated and has become the commonest cause of children being admitted to hospital. This rising tide of asthma has failed to stimulate an interest in allergy in more than very few children's specialists. As a result, treatment is directed towards discharge home as soon as possible, without enquiry or tests to find the cause of the attack. Investigations are seldom carried out, as most British doctors have not been trained to investigate allergies - but repeated admissions can result from causes in the home which could be identified, avoided or removed. Children who have repeated acute attacks often become severe chronic asthmatics, dependent on drugs for a restricted existence. Many do not 'grow out of it' and become adult respiratory cripples who serve a life sentence from asthma.

Today's drugs are the most powerful ever devised, but are often not used properly or effectively. The worst cases may become indefinitely dependent on steroid tablets, with many well known side-effects, which do not occur with inhaled steroids. Detailed investigation for allergies is essential in these severe cases, but seldom done because specialists with the necessary knowledge and expertise are very rare indeed. In 1986, injections to desensitise allergic patients were made impossible. As a result, many doctors now assume, quite incorrectly, that investigations to find a cause are not worth doing, and dependence on drugs is now complete in Britain.

In spite of advances in drug treatment, deaths from asthma in children and adults are increasing. Mismanagement has been repeatedly found to be a major cause of prolonged misery and even death, so the lot of the British child with asthma may be a most unhappy one. Belated steps are now being taken to provide allergy specialists under the NHS, but will take many years to establish. What can be done meanwhile, especially for the really severe asthmatic child dependent on oral steroids, a high risk group with poor future prospects?

In Europe, asthmatic children not only have the benefit of allergy specialists but can be sent to hospitals in the mountains, where the air is free from pollution and pollen, no dust mites live over 3,000 feet and the environment is free from dust and pets. Special hospitals and schools are provided, conditions are ideal, and the bulk of the costs are met by French social security or medical insurance. No such facilities exist in Britain.

In this environment, improvement is usually rapid. Most drugs, particularly steroid tablets, can be stopped or reduced quite quickly, and the children begin to live a normal life at last, and take part in many activities. A stay of a minimum of three months is necessary to allow the respiratory system to become normal again. Most importantly, at least half of the children remain well after they return home.

The European Society for Climatotherapy has now agreed, at the suggestion of the only British Member, Dr H Morrow Brown of the Midlands Asthma and Allergy Research Association, to accept British children between the ages of 7 and 15 so that they also can share in the remarkable benefit of high altitude treatment in Briançon, 4,500 feet up in the French Alps near Grenoble.

The problems are to find the most severe asthmatic children, select those most likely to benefit, convince the parents it is worthwhile going to France for at least three months, and then to find the money to sponsor the scheme. MAARA does not have the funds, so either public support or company sponsorship will be sought for up to 12 children in the first year. The cost per child for three months will be between £4,000 and £5,000.

Names and details should be submitted by parents or family doctors to MAARA, 12 Vernon Street, Derby for consideration. Full information is required to help in assessment for their suitability for treatment. Even if they never go to France, the children will have the benefit of expert investigation and treatment recommendations.

Dr H Morrow Brown

MIDLANDS ASTHMA & ALLERGY RESEARCH
— ASSOCIATION —

Mrs. M. A. BEASTALL & Mrs. B. BAILEY

Invite you to a

Coffee Morning

at The Mayor's Parlour, Council House
Corporation Street, Derby

on Tuesday 26th April 1988 10.30 a.m. to 12 noon
Bring and Buy — Raffle — Cake Stall

ADMISSION 50p

FOOD FOR THOUGHT or THE NOT SO HUMBLE POTATO

Christopher, aged 5, has a mother with a very strong personality. She refused to accept that his frightful behaviour from infancy onwards, followed by the development of asthma from age 3½, could in any way be her fault for being a fussy mum. There were times when she was down to her doctor's several times a week or even more than once a day, and finally arrangements were made for me to see him about possible allergies. He was big for his age, with a marked pot belly and heavy circles under his eyes, couldn't sit still and was almost impossible to examine or to do any skin tests on. This kind of behaviour always suggests food allergy or intolerance problems. His pot belly had been said to be due to obesity, but when I asked about his motions, mother said that they were large and very smelly and floated on the water. This is the type of motion associated with coeliac disease or malabsorption. He also had excessive thirst and bed wetting. He had been in hospital twice with his asthma but these facts had not come to light. Furthermore, his mother stated that if for any reason he was totally unable to eat for a few days, he suddenly became a lovable little boy.

Everything seemed to point to a possible food intolerance problem, so he was put on a diet of lamb and rice for a trial period. In order to encourage him, mother and father also went on the same diet.

As far as Christopher was concerned, within two days the pot belly began to disappear, his awful motions ceased, and he became a lovable little boy. The thirst and bed wetting also ceased. The change in behaviour was noted not only at home but also at school, where it was found that his writing and drawing improved.

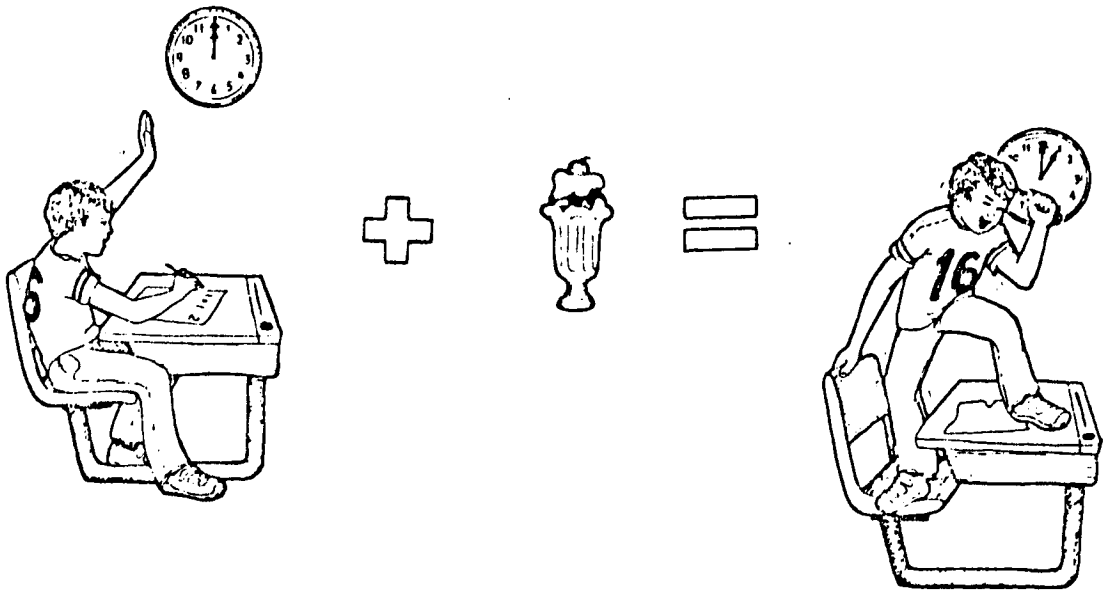
The surprise was that his father's personality also changed dramatically for the better, so instructions were given for foods to be added one by one to their diets to see what would happen. They found that every time Christopher or his father ate potatoes they became difficult, aggressive and nasty. Introducing wheat produced the dreadful smelly motions again, but not on gluten free products. Further detail was that the family didn't have much potato during the week, but on Friday father usually had chips at lunchtime. By the time he came home he wasn't fit to be with! This could also happen if he had chips or crisps at the weekend. He also found that milk or cheese would make him miserable within the half hour.

By avoiding gluten, potato and milk, Christopher is a different boy in every way, lost his pot belly, and has become a lovely cheerful little boy. Father's new personality is also greatly appreciated. The third

member of the family, baby Nicky aged 6 months, has also been helped, because he also had chronic diarrhoea and colic, sometimes with very nasty stools indeed. Substitution of a soya formula and using gluten free products abolished all these symptoms.

This unusual family case history shows not only how food intolerance can be apparently inherited, but also how dietary manipulation was capable of producing a new father, a new son and a new baby. It was fortunate that mother persisted in trying to get informed help with his problems and finally achieved this remarkable result.

Dr H Morrow Brown



UPDATE ON ASTHMA IN CHILDREN

Every doctor in the country gets the Drugs and Therapeutics bulleton free every fortnight. This publication reviews treatment of various conditions and new drugs.

The latest issue makes some very positive suggestions regarding assessment, diagnosis and treatment. A few points are worth printing in our Newsletter for example - 'Parents should be told to get help if more than 6 - 8 puffs of a bronchodilator such as Ventolin are needed in one hour'.

It is pointed out that 'nebulisers are useful, but that in acute asthma the child may not respond for longer than an hour and that steroid tablets should also be given for 3 - 5 days'. More importantly, it is emphasised that the child should be reassessed within 2 - 3 hours and if still deteriorating after two successive hourly doses of a nebuliser, should be

admitted to hospital'.
Another positive recommendation is for the use of steroid tablets by mouth early in an attack, and that as much as six 5 mgm steroid tablets in one single dose can be given to pre-school children and will often bring an attack under control. Having some steroids at home is encouraged yet many family doctors still do not prescribe steroids.
Those of our members who have young asthmatic children should note these points.

-oOo-

The article below has been reproduced from the newsletter of an American support group, "Mothers of Asthmatics Inc." Although the vocabulary is American, the message remains the same.

"HE REALLY DOESN'T SOUND THAT BAD"

It is 11 pm. Last night was a nightmare and now it looks as if your child is going to have another rough night. So rather than wait until the crisis is full blown, you bundle your 'wheezer' and take him to the emergency room. The triage nurse checks him in, listens to his chest, jokes that it sounds like an orchestra tuning up, then fetches the doctor. The doctor pulls the curtain back, gently listens to his chest and then proclaims, "He really doesn't sound that bad."
Unless the parent has been well educated by the child's doctor, the parent will most likely be confused by this statement. He or she will be more likely to wait until the attack has progressed to the danger point the next time as the result of having been made to feel foolish.
An experienced, knowledgeable parent will discard this statement, will monitor the child based on his history and peak flow meter readings and determine if it is necessary to call the child's own physician (GP).
If what the doctor really means by his statement "He really doesn't sound so bad" is that he thinks that he will be able to clear the child's chest with standard treatment or that he is glad that the child is not in immediate danger of dying, he should make these statements clear.
The emergency room is a place to take your child when your best efforts to control your child's asthma according to the plan defined by your doctor fail. This happens to most of us at some time or another. It should not be used in lieu of appropriate medical care by a G.P. or a specialist.
Last Spring, our daughter reached the point where I had to take her to the emergency room. I called our own doctor first, who called ahead

to the hospital. Unfortunately, the doctor to whom we were directed was not the one which our doctor had briefed. "She's not so bad" was his statement, based on the fact that he heard only faint wheezing when he listened through his stethoscope.

Someone less aware than I might have been encouraged by this, or may have felt that she had made a mistake in deciding to bring the child to hospital. However, I knew from her peak flow readings that her lungs were so restricted that they were barely moving air at all. A wheeze is the sound made as air passes through constricted airways. Doctors well-trained in the treatment of asthma know that in severe cases, the absence of a wheeze can be a very dangerous sign, indicating that the airways have become so blocked that air cannot pass through at all.

Because I knew that she was in serious trouble, I persisted and minutes ticked away as I convinced him that the situation required more than casual treatment.

To cut a long story short, we came close to losing her that night.

"Not so bad" can mean many different things.

-oOo-

'FAMOUS MEDICAL QUOTATIONS'

Sydney Smith [1771-1845]

I am suffering from my old complaint, the hay-fever (as it is called). My fear is, perishing by deliquescence; I melt away in nasal and lachrymal profluvia. My remedies are warm pediluvium, cathartics, topical application of a watery solution of opium to eyes, ears, and the interior of the nostrils. The membrane is so irritable, that light, dust, contradiction, an absurd remark, the sight of a Dissenter, - anything, sets me sneezing; and if I begin sneezing at twelve, I don't leave off till two o'clock, and am heard distinctly in Taunton, when the wind sets that way - a distance of six miles. Turn your mind to this little curse. If consumption is too powerful for physicians, at least they should not suffer themselves to be outwitted by such little upstart disorders as the hay-fever.

Letter to Dr Holland, June 1835.

What after Desensitisation?

by Dr. M. A. Stern

You, if you have asthma, want to be cured, but we doctors give you 'maintenance therapy', drugs which you often have to take for the rest of your life. You dislike this, but we badger you to use your drugs regularly, to use inhalers correctly (even though we know that this is a bit of a disaster area for rather a lot of people), and to get in touch with us early whenever your asthma seems to be getting out of control. Increasingly (following pioneering work in Derby by Doctor Morrow Brown), we are asking you to use a peak flow meter twice a day. Everyone wants a normal life. What sort of normal life is a routine of daily medication?

After years of study and research, we still read articles in medical journals like 'Thorax' that many people with asthma are seriously undertreated, and that readily available treatments would let them lead better, even near-normal, lives. We also read, as if we needed to be told, that we still have many patients whose asthma continues to wreck their lives in spite of the best of treatment. The titles of two recent articles were "The Difficult Asthmatic" and "The Catastrophic Asthmatic". Which is difficult and catastrophic, the asthmatic or the treatment?

Death from asthma

The chance of dying from asthma has not fallen since a century ago, according to Sir Richard Doll, whose reputation in these matters has been public knowledge since he jointly discovered that smoking caused lung cancer. More accurately, about the same proportion of the whole population dies from asthma now as then. But what about all the new drugs, inhalers, nebulisers and peak flow meters, all the new hospitals, and the proliferation of Intensive Care Units intended to save the lives of people with asthma? That all these good things have not reduced the death rate is something which confounds the experts. People have wondered whether the treatments actually make things worse in the long run, but the solid consensus is that far far more patients die from undertreatment than from overtreatment.

Asthma a way of life?

Might there be another way of looking at the problem? We think that the proportion of people with asthma has truly increased during this century. It is not just better diagnosis. House mites breed faster at the higher room temperatures we achieve with central heating. Could this influence, throughout our lives, be important? You cannot clean fitted carpets as well as the loose ones which were taken outside and whacked with a carpet-beater. You can't even find a decent carpet-beater nowadays. With most women working outside the house, who finds time to whack carpets anyway? (Perhaps whacking carpets would be good for getting rid of aggression, but that is another story.)

Good asthma drugs may mean that people no longer avoid the cause of their asthma as they used to. No-one *likes* to be prevented from visiting others just because they get asthma from the dog, but with effective inhalers, you needn't be prevented. So you don't get asthma, but you do breathe dog dust and make more antibodies. You can't feel the antibodies; they appear slowly over the next month. Perhaps by suppressing

the symptoms we worsen the disease process.

Stopping the shotgun pellets

Much asthma research now tries to block what happens in your lungs after the allergic trigger for asthma has been pulled. Police who have tried stopping men with sawn-off shotguns this way have paid a grievous price. Is it possible that people with asthma will pay a grievous price for the concentration of so much research on this approach? Is the preventive approach, like the friendly bobby on the beat, not a better one? Should we not have more people researching how to switch off the making of those antibodies which start the whole thing, or how to alter the immune process so that the harmful IgE antibodies are rendered harmless? An amazing amount is known about the immunology; can't we put it to better use?

What of desensitisation?

Dr. Morrow Brown has done more research on desensitisation than any doctor in Britain. In Leicester we recently tried a new idea, but after three seemingly brilliant results our experience was not good. Desensitisation works, but usually only partly, and often not enough. Five deaths in the UK over 18 months from desensitisation (not in specialist units) led the Committee on Safety of Medicines to take draconian and perhaps somewhat irrational action in 1986, making desensitisation all but impossible even in specialised units with good safety records. Colleagues in France and the USA point to their astounding records of safety, but to no avail here. It is just now impracticable for us to get funding for further desensitisation research in Britain. The manufacturers, the only likely source of funds, are almost out of business.

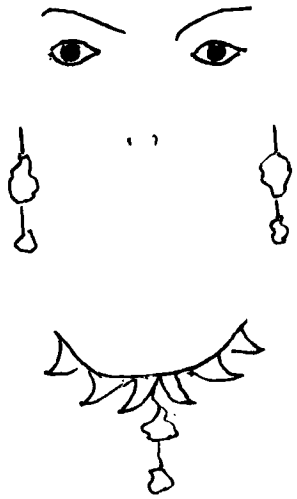
New directions and MAARA

For the time being British research on asthma treatment has to take other directions. We have to improve our research on existing treatments. We will continue to test new drugs. We must explore ways to control house dust mites. We may find other ways of altering antibody responses.

MAARA will continue to be vital for this work.

Dr. Deirdre Robertson

In Leicester, we welcome Dr. Deirdre Robertson, who has joined us as Clinical Trials Scientist. This is the first time that MAARA has employed a professional pharmacologist to run treatment trials and study the action of treatments for asthma and allergies. (A pharmacologist is a scientist in the field of drug actions, and is not the same as a phar-macist, someone professionally qualified to dispense drugs.) Clinical trials are crucially important both to our patients if we are to improve their treatment, and to MAARA. It is however vital that they be done very well; the history of asthma research in par-ticular is replete with stories of good drugs being wrongly turned down, and poor drugs being given a most enthusiastic thumbs-up. All treatments can potentially produce side-effects, and watching out for these is especially important in clinical trials. More generally, we want to build up a good scientific unit, and the appointment of Dr. Deirdre Robertson is important for this.



PRELIMINARY ANNOUNCEMENT

JEWELRY EXHIBITION AND FAIR
****

Thursday 27 October at

The Pennine Hotel

organised by Mrs Patricia Haynes
of the Inner Wheel

Tickets £9 Champagne & Nibbles

Discounted purchases- Auction - gifts
donated by famous jewelry houses

****

EGGLESS & MILKLESS RECIPES

Kindly supplied by Mrs Janet Bardill

CUSTARD SHORTBREAD

12 oz plain flour
2 oz custard powder
8 oz Granose margarine
4 oz icing sugar

Mix together to a dough-like mixture and bake in two round 8" tins for half an hour at 335°F.

OR Roll into sausage shapes, roll in brown sugar, cut into thick slices and bake on tray, timing according to the thickness.

Better kept in a tin for a few days before eating.

CHOCOLATE FUDGE CAKE

4 oz Granose Margarine)
3 oz sugar)

Melt together in a saucepan.

Add 1 tablespoon cocoa (not drinking chocolate)
4 oz SR flour
3 oz coconut

Mix all ingredients together well. Spread into shallow baking tray and bake for 10 minutes at 375°F. This mixture will still be slightly soft. Take out of oven and leave for a few minutes.

Icing sugar + enough water to make coating consistency

Ice whilst hot and score. Leave to cool and remove from tin.