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BC's Hepatitis C News Bulletin

February 1999 **Issue No. 9**

HEPATITIS C AND POLICE WORK

By Leslie Gibbenhuck

Hepatitis C is an epidemic, affecting over 200 million people worldwide. Why then, is so little known about this insidious disease?

There have been many articles published on the risks of transmission of hepatitis C. All "emergency workers" are high risk. Not only do police officers work with the sector of the population most at risk (prison, drug users, drunks) but they are also first responders to motor vehicle accidents and domestic disputes.

Police officers have also been known to use physical force to restrain and/or arrest. It is common to come in to contact with blood and bodily fluids, either through direct contact with individuals or through gathering evidence in the course of an investigation. Blood and other bodily fluids are usually crucial evidence and are actually sought out by police officers.

Until recently no police officer was advised to wear gloves (nitrile are best—as viruses may permeate wet latex gloves), protective eye wear, or to create barriers (masks and protective clothing) between themselves and their customers.

Transmission may occur with exposure to blood (100% of the time), saliva (48%), seminal/vaginal fluid (24%) and urine (7%). If there is any risk of transmission, the employer has a legal and moral obligation to safeguard its employees by whatever means reasonably possible. It is far more responsible to err on the side of caution, than to dismiss the facts.

2. Are police officers told...?

- Unlike HIV, hepatitis C can live outside the body for 7 days (although it has also been reported to live up to 6 weeks on a hard surface!)
- There is no vaccination for hepatitis C - you are not immune!
- If you have hepatitis C, you should be vaccinated for hepatitis A and B.
- To get tested annually for all other possible work acquired viruses or at least after exposure to any blood or bodily fluids.
- About the guidelines to officers about work-acquired illnesses. Are they told to have themselves tested, to follow-up (daily) exposures to hazardous situations?

Canada Labor Code

The Canada Labor Code provides employees with three rights

1) the right to know

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PAIN MANAGEMENT

by Darlene Morrow

I was recently asked what are we supposed to do when we have a painful episode. This question was asked about back spasms and anti-inflammatories. People are frustrated by the recent warnings about Ibuprofen. Tylenol is out, so what is left?

First and foremost, you have to discuss this with your physician. Preferably your specialist. All bodies react differently to drugs. Your specific stage of liver disease will also play a big role in the decision making. But a little information beforehand will enable you to prepare careful questions for your physician.

At a recent St Paul's conference Dr Anderson replied to a question about whether Tylenol was okay for HCV patients and he replied that it was the lesser evil—but only 2 regular strength or 1 extra strength. We are talking about a short duration episodes—not something that is taken on a regular basis.

Anti-inflammatories have been studied in HCV to see if they would be a useful adjunct to interferon therapy. The rationale was that there can be significant inflammation of the liver so then perhaps the anti-inflammatories would provide a benefit. Studies have looked at both Orudis (ketoprofen) and Indocid (indomethacin). The research found that it didn't make a difference in the response rate. But are these drugs harmful to the liver?

There are almost as many types of anti-inflammatories as there are people. The reason there are so many is that they have a different effect on different people. One anti inflammatory may totally erase pain in one individual and have no effect on another. No one really knows how you will react until you take it.

One of the biggest concerns with anti-inflammatories is that they cause a reduction in the mucosal lining of the intestinal tract. This allows the acid in your stomach free access to the lining of the tract and the results can be devastating. Many people end up in the hospital or die as the result of a bleeding ulcer. You might think that you would feel pain before this developed to the point of an ulcer but the drug works in pain prevention and can block the very sensation that would alert you.

I think that the dangers for those with hepatitis

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THE LAST RESORT…

Liver Transplantation

By Joan King-Diemecke

Do I need a liver transplant?

You may be a transplant candidate if you are in "end stage liver disease" (ESLD). The decision to transplant is made by a team of about 10 people, who evaluate you and decide if you will actually benefit from the transplant. You must be healthy enough to survive the operation and have no other serious disease. Symptoms of ESLD are jaundice, or yellowing of the skin and eyes, fluid retention, fatigue, problems with clotting, indications of portal hypertension, muscular wasting, and bleeding from the esophagus or stomach. The doctors look at how long you have had these symptoms and if they are getting worse. They also look at the cause of the liver disease (viral hepatitis, alcohol, etc.) In BC, if you are "listed," you will already be using the maximum amount of medication available, and will usually have tried treatment such as interferon. You will be on the maximum dosage of diuretics (water pills), will not be a candidate for a shunt (in other words, you will *not* have extreme confusion, which is made worse by a shunt) and will usually have experienced a bleed or coma. There will be no other option to consider.

Am I eligible for a transplant?

Factors considered are general health, age, compliance with past medical treatment, support systems available for post-transplant care, present substance abuse, how sick you are, how long you have been waiting, how well-matched the donor is in weight, height and blood type, where

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NANCY FERGUSON

We received the sad news from her daughter Muriel and son Scott of our dear Nancy's demise last December 28th. Nancy, 68, born in Scotland, was transfused in 1989. She also left behind her son, Ian, and two grandchildren.

Some of you will remember Nancy from our meetings and rallies.

Her unique elegance and bright smile will be sorely missed.

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1611 Quadra St.
Victoria, BC V8W 2L5

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SUBMISSIONS: ***The deadline for any contributions to the* hepc.bull *is the*** 15th of each month. ***Please contact: Joan King-Diemecke at (250) 388-4311,*** joan_king@bc.sympatico.ca, ***Darlene Morrow at 1203 Plateau Drive, N. Vancouver, BC, V7P 2J3,*** hepcbc@home.com ***or C.D. Mazoff at*** squeeky@pacificcoast.net
The editors reserve the right to edit and cut articles in the interest of space.

ADVERTISING: ***The deadline for placing advertisements in the* hepc.bull *is the 12th of each month. Rates are as follows:***
Newsletter Ads:
$20 for business card size ad, per issue
There will be a maximum of 4 ads in each issue, and the ads will be published if space allows. Payments will be refunded if the ad is not published. Ads are also posted to the Web.

Victoria Chapter Volunteers

If you are good at organising events, such as Ribbon Day or the Fun Run, please call and volunteer your services. 388-4311.

If you'd like to receive email rather than phone messages about upcoming meetings, rallies, and other Chapter news, email us:

hepcvic@pacificcoast.net

We need a library volunteer one morning a week, to work in the office. Experience with a computer desirable. Contact 388-4311.

COMING UP IN BC:

Castlegar/Grand Forks/Trail Contact: Robin, 365-6137.

Chilliwack Contact: David, 792-3467.

Comox Valley Liver Disease Support Group Meetings: Third Tuesday of each month, 7 PM, downstairs, Island Health Unit building. NEXT MEETING: Feb. 16th. Contact: Ingrid or Nicky, 335-1711 or Jeanne Russell ebus96@island.net

Cowichan Valley Hepatitis C Support Services. Meetings: 1st Thursday 7-9 PM. 464 TCH. Duncan. NEXT MEETING: Feb. 4th. Contact: Debbie, 748-5450 or Leah 748-3432. vhepc@hotmail.com

Enderby HepCURE Meetings: Last Sunday of each month 2-4 PM, for High Tea, The Raven Gallery, 701 George St. NEXT MEETING: Feb. 27th. Contact: Marjorie, 558-7488. www.junction.net/hepcure/index.html

Kelowna HeCSC Meetings: Last Saturday of each month, 1-3 PM, Rose Avenue Education Room in Kelowna General Hospital. NEXT MEETING: Feb. 26th. Contact: Michael, 860-8178 or eriseley@bcinternet.com

Nanaimo HeCSC Meetings: Second Thursday of each month, 7 PM, Health Unit-Central Vancouver Island, 1665 Grant St. NEXT MEETING: Feb. 11th. Contact: Helen, 245-8759.

New Westminster Support Group Meetings: Second Monday of each month, 7:00-8:30 PM, First Nation's Urban Community Society, Suite 301-668 Carnarvon Street, New Westminster. NEXT MEETING: Feb. 8th. Contact Dianne Morrissettie 525-3790.

Parksville/Qualicum 163 Memorial Street, Parksville. Open daily from 9AM to 4 PM, M-F. Contact: (250) 248-5551. dbamford@island.net

Penticton HeCSC Meetings: Penticton HeCSC Meetings: Second Wednesday of each month, 7-9 PM, Penticton Health Unit, Board rooms. NEXT MEETING: Feb. 10th. Contact: Leslie, 490-9054, bchepc@bc.sympatico.ca

Prince Rupert Contact: April, 627-7083.

Quesnel Contact: Elaine, 92-3640.

Richmond Meetings: Fourth Tuesday of each month, 7 to 9 PM, Westminster Health Unit, 7000 Westminster Hwy., main floor, room 3. NEXT MEETING: Feb. 23rd. Contact: Guy, 244-1704. guy@fatherswithoutchildren.com or Carmel at Richmond Health Unit, 279-4069.

Sunshine Coast Meetings: First Thursday of each month, 7:30 PM, Coast Garibaldi Health Unit in Gibsons. NEXT MEETING: Feb. 4th. Guest Speaker will be Dr Loreen Dawson, Naturopathic Physician Contact: Karen, 885-6413. karen_felske@sunshine.net

Vancouver CLF Meetings: Second Thursday of each month, 7:30 PM, Nurses' Residence of VGH (12th and Heather). Signs will direct you. NEXT MEETING: Feb. 11th. Contact: the CLF, 681-4588 or Herb, 241-7766. HMoeller@compuserve.com

Vernon HepCURE Meetings: 1st Tuesday 12-2 PM and 3rd Tuesday of each month, 6-8 PM, the People Place, 3402-27th Ave. NEXT MEETINGS: Feb. 2nd and 16th. Contact: Marjorie, 558-7488. www.junction.net/hepcure/index.html

Vernon HEPLIFE Meetings: 2nd and 4th Wednesday of each month, 10 AM-1 PM, The People Place, 3402-27th Ave. NEXT MEETINGS: Feb. 10th and 24th. Contact: Sharon, 542-3092. sggrant@attcanada.net

Victoria HeCSC Meetings: Last Wednesday of each month, 1-3 PM, speaker: Dr. Peter Bennet—Helios Clinic, and at 7-9 PM, St. John the Divine Church Lounge, 1611 Quadra St. (Entrance through the rear, marked Annex) NEXT MEETING**:** Feb. 24th. Contact: 388-4311. hepcvic@pacificcoast.net

White Rock Support Group: Meeting Room #2, Peace Arch Hospital. Contact Lisa Peterson at 538-8704

REPRINTS

Past articles are available at a low cost. For a list of articles and prices, write to the *hepc.bull*, via Darlene Morrow at 1203 Plateau Drive, N. Vancouver, BC, V7P 2J3, hepcbc@iforward.com

THANKS!!

Victoria Chapter HeCSC acknowledges the personal donations, donations in kind and memorial donations received to date, and the following for discounts, donations of services, or equipment: Monk Office Supply. CFAX 1070 Radio, Apple Canada, Pacific Coast Net and Island Internet, Inc., Mid-Island Realty, Questar Holdings, Unity Business Machines Ltd., Microsoft of Canada, Jim Pattison Group, Society Press & Graphics, Paradon Computers, and CompuSmart. We also wish to acknowledge an anonymous agency which has generously supplied us with government surplus computer equipment. Special thanks this month to Robert Myles, Susan Keys, Olive Petrou & Marilyn Timms.

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SQUEEKY'S CORNER

My Take on the Compensation Deal

by Jo-Anne Manser
Ottawa Chapter

In a nutshell, the entire process stinks—a process orchestrated from the beginning by Allan Rock's office.

My main points of disagreement with the proposed agreement are:

- Levels of compensation based on levels of sickness
- Amount and process not comparable to HIV victims even though the crime was the same.
- Negotiation in the absence of justice

Why do we entertain any discussion without demanding complete honesty in this issue? The whole thing is based on a *LIE*—86 to 90 unique liability is a *LIE*. And the package has been negotiated by criminally implicated representatives and thieves. In halting the release of damaging evidence of their guilt by engineering HeCSC to back off from finding fault (*which strengthened our position*), the government successfully watered down the argument for compensation for all by silencing the accusers. However, they were not prepared for the Arkansas blood story—so perhaps the truth will come out in spite of it all.

Following are specific areas of the "deal" that I disagree with and why.

"*Level of need" or "level of sickness/suffering":* If we were dealing with an honest system of government, that had nothing to fear or to hide, we might accept that they would be acting in the best interest of the people who had been injured. However we are not. Therefore, who determines levels of need or suffering or sickness? Let us start with defining "sickness." Is sickness defined as how one feels, how one looks, or is it based solely on supposedly objective clinical data? In the case of HCV we know that the only predictable thing is its unpredictability. It is important to keep in mind that viral load testing is not being done on many patients, and that the sensitivity of the test is in question. It is possible to have virus present in the blood system at such low levels as to be undetectable by current PCR testing. One may be HCV positive but tests show no virus present, when in fact the virus is present but at low levels. The resulting false sense of security will certainly lessen patients fears, and save the compensation fund money because based on these tests the person would not qualify for recompense, probably not until they were too sick to do anything about it. It has been known for cirrhosis and significant liver damage to be present in HCV even though ALT levels are normal or only moderately elevated. The person may even look and feel quite well. How often have doctors and patients' families been confounded when a supposedly asymptomatic patient suddenly slips into a hepatic coma, has a GI bleed or dies unexpectedly from "complications" of seemingly minor surgery? In HCV, extra-hepatic disease and sickness, while recently being acknowledged by medical professionals, is still not clearly defined. Some doctors still claim that illness not involving liver disease has nothing to do with Hep C and yet we know that a host of extra-hepatic symptoms are common.

"No-fault" & "Compassionate Assistance": I believe it's important to set something straight in terms of the words that have been used throughout this process, and their misinterpretation and misuse. The first term is "no-fault" compensation. Justice Krever's analysis was quite right. In short, it would get money quickly to those victims who desperately needed help. Fine. Except that Allan Rock et al. twisted and perverted the "no-fault" scheme, and hence its meaning, expressly for legal defence purposes to set up legal evidence of no liability (no-fault—get it?). "Compassionate assistance" is another misleading phrase loaded with legal ramifications. If assistance is being offered on a compassionate basis, the absence of legal liability is implicit. Further it can be taken as a gesture of goodwill and creates an impression of a benevolence, speaking to the "good character" of the defendant(s). And so, while Joe Public understands compassion and no-fault compensation one way, crafty legal minds know exactly what these terms really mean.

The whole discussion, about the details of compensation and the process for dispensing the blood-money at this point, is rather useless. But it does successfully derail any discussion or action on justice. After all, if the Hepatitis C Society favours "no-fault" then no one is at fault, right? This means then that we are strictly dealing with a "compassionate assistance package" similar to that resulting from "medical misadventure" when someone was "asleep at the switch." The task now becomes one of individuals grappling for their fair share of the "benefactors compassionate relief" money. Right? In reality HeCSC has accepted a stance that has played them (and thousands of truly innocent victims) directly into the hands of the enemy. Make no mistake—the enemy is and has always been the criminals who committed the crime and their accomplices, both past and current—the Federal Ministry of Health, senior Red Cross officials and multinational pharmaceutical companies who are the real hidden criminals driving our government into corruption in the name of profit and power.

The hepatitis C issue in the tainted blood scandal has triggered a shocking revelation of truths which have been covered up at great expense for decades. Our moral climate has shifted allowing us to accept the unacceptable and to tolerate what is intolerable. We bear witness to the pain and suffering on a very personal level and yet are expected to dispassionately analyse and negotiate with the perpetrators—as if there were no other choices.

As a former board member who witnessed months of extremely suspect activity I have viewed this entire sham with a heavy burden for

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LAB TESTS

From- Focus: on Hepatitis C

ALT
(Alanine aminotransferase serum)

ALT, an enzyme appears in liver cells, with lesser amounts in the kidneys, heart, and skeletal muscles, and is a relatively specific indicator of acute liver cell damage. When such damage occurs, ALT is released from the liver cells into the bloodstream, often before jaundice appears, resulting in abnormally high serum levels that may not return to normal for days or weeks.

The purpose of this blood serum test is to help detect and evaluate treatment of acute hepatic disease, especially hepatitis, and cirrhosis without jaundice. To help distinguish between myocardial (heart) and liver tissue damage (used with the AST enzyme test). Also to assess hepatotoxicity of some drugs.

ALT levels by a commonly used method range from 10 to 32 U/L; in women, from 9 to 24 U/L. (There does exist differing ranges used by various laboratories.) The normal range for infants is twice that of adults.

Very high ALT levels (up to 50 times normal) suggest viral or severe drug-induced hepatitis, or other hepatic disease with extensive necrosis (death of liver cells). (AST levels are also elevated but usually to a lesser degree.) Moderate-to-high levels may indicate infectious mononucleosis, chronic hepatitis, intrahepatic cholestasis or cholecystitis, early or improving acute viral hepatitis, or severe hepatic congestion due to heart failure.

Slight to moderate elevations of ALT (usually with higher increases in AST levels) may appear in any condition that produces acute hepatocellular (liver cell) injury, such as active cirrhosis, and drug-induced or alcoholic hepatitis. Marginal elevations occasionally occur in acute myocardial infarction (heart attack), reflecting secondary hepatic congestion or the release of small amounts of ALT from heart tissue.

Many medications produce hepatic injury by competitively interfering with cellular metabolism. Falsely elevated ALT levels can follow use of barbiturates, narcotics, methotrexate, chlorpromazine, salicylates (aspirin), and other drugs that affect the liver.

Be Aware: Serum liver enzymes can create confusion for both patients and physicians for these tests are highly sensitive, but very nonspecific. Tests commonly referred to as liver function tests or LFTs do not actually determine liver function. Instead, they are static, primarily diagnostic parameters that serve to detect liver disease rather than quantitative liver function.

Rather than liver function tests, it is more useful to refer to these tests as serum liver tests and to mentally categorize them according to the pathophysiologic processes they truly reflect. The serum liver enzyme AST (formerly known as SGOT) and ALT (formerly known as SGPT) are

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(**POLICE**-*Continued from page 1)*

2) the right to participate, and
3) the right to refuse dangerous work.

This puts police officers in an awkward position, almost all of their work can be classified as "dangerous." "Through provisions of the Code, employees have a right to know about known or foreseeable hazards in the workplace and to be provided with the information, instruction, training and supervision necessary to protect their safety and health."

3. Employers' Responsibilities

The onus should not be on the individual but on the employer to inform police officers of known or foreseeable hazards—when infection can occur without their specific awareness. *Hepatitis C is a preventable disease.* There is no effective treatment, no vaccination and no cure!

The employer has a duty to protect the health and monitor the health status of police officers. Have officers been tested as part of an annual physical?

In the absence of such vigilance (regular testing) the employer cannot reasonably argue its members should have been monitoring their status, so as to be able to pinpoint a specific incident.

*When Hepatitis C blood work was added to the annual physicals of Orange County firefighters, fire officials and state health experts were alarmed at the high rate of infection.

Dr. Jeremy BROWN

Dr. Jeremy BROWN had a paper published in the *Journal of Clinical Forensic Medicine* in 1995 on Risk to Police Officers from Biohazards Encountered in Police Work. Although he has little to say about hepatitis C, he does warn of "the virus' propensity to cause serious conditions including chronic hepatitis, cirrhosis and hepatocellular carcinoma. The consequences are severe."

He also reports conflicting observations about the increased risk among health care workers but does add that hepatitis C can be transmitted through accidental needle stick and the risk is moderate—between that of HIV (low) and hepatitis B (high).

4. Nevertheless, transmissions by needlestick and bite are documented. Dr Brown warns of the necessity for police forces to remain abreast of all developments in research and awareness. Keep in mind this paper was written in 1995, almost four years ago, when very little was known about hepatitis C or its transmission.

Developing a Protocol—as described by the CDC, Atlanta, Georgia: Issues that need to be considered when developing a protocol for the follow up of workers occupationally exposed to hepatitis C.

1) Limited data about the occupational risk of transmission
2) Limitations of available serologic testing for detecting infection and determining infectivity
3) Poorly defined risk for transmission by sexual and other exposures
4) Limited benefit of therapy for chronic disease
5) Cost of follow up
6) Medical and legal implications
7) Immediate vaccination for hepatitis A & B

A national survey of U.S. and Canadian paid fire departments found that 90% of all firefighters provide some level of medical care in the community. On average 77% of the fire departments in U.S. and Canadian cities with populations of 1 million or more provide first-responder services, 80% basic life support, and 50% advanced life support. This applies to police officers as well.

5. Although no case studies have been done to support the allegation that there is a higher rate of infection among police officers, there has not been mandatory testing to deny this claim either.

How does one know how long they have been infected with hepatitis C? There is no definitive test to determine the moment of infection. The onset of chronic illness varies from person to person. Transmission and symptoms are two of the many puzzling features of hepatitis C.

Most people infected with hepatitis C do not know about their infection because there has been little effort made to notify or educate them or to advise them of treatment possibilities and lifestyle changes.

Precedents Being Set:—James Edward Petrowitz versus City of La Crosse Fire Department

Hepatitis C is contained in the blood of the person who is the carrier. It is possible to have the virus without symptoms. Evidence shows it is very common for a firefighter to be exposed to blood of various people. They will often arrive at the scene of accidents, shootings, child births and other incidents before the ambulance.

The word “firefighter” could be interchanged with “police officer.” But police officers have many other exposures as well—add digging through dumpsters and crime scenes, patting down prisoners, attending fights and disputes, arresting and subduing criminals, being spat at, and contact with the prison population (reported infection rate of 78% in recent random Texas testing).

It was found in the case of Petrowitz that hepatitis C infection was work-related and that he was entitled to benefits. While in performance of his duty he contracted the disease, which is permanent and which caused him to retire from his job, prematurely.

6. It has been established that prisoners who throw blood or bodily waste on guards can expect extended prison terms. If they are infected with HIV, hepatitis or TB the penalty can be increased by 5 extra years.

New York correction officers who acquire HIV, hepatitis or TB will be getting a big pension hike under a Governor Pataki bill. This entitles correction officers to tax-free disability pay worth 3/4 of their final

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(**TRANSPLANT**—*Continued from page 1)*

the donor is. If you have abused drugs or alcohol in the past, you must be sober for 6 months, and must undergo, or have undergone rehabilitation in a witnessed abstinence program, and sign a contract for lifetime abstinence, where you agree to submit to drug and alcohol screening at any time.

What tests are used to assess candidates?

Blood typing tests are done. (Types A and O are the most common blood types of organs received in B.C.) Patients are screened for heart, kidney and lung disease, AIDS, and the presence of cancer which would prevent a successful transplant. Even teeth are checked. CAT scans are done, and an echocardiogram is performed. These last two tests have an average wait time of 6 to 8 months. Most candidates have a psychiatric evaluation and/or an appointment with a social worker to ensure their ability to comply with the routines required after a transplant. These tests can take several weeks. It's a good idea for the patient to have copies of medical records and reports and bring them to the evaluation. This can save time and effort in obtaining old records. In Vancouver, patients being evaluated for transplant are scheduled for appointments every 3 to 6 months, depending on the stage of their illness. They are assessed during that time. If you are very ill, they can often assess you in 6 weeks. In an emergency case, the patient is admitted to the hospital to speed up the testing process.

I'm on the list. Now what?

Once on the list, you must be available 24 hours a day. You are given a pager (beeper), and notified when an organ is available. The wait may take many months. In the meantime, you are advised to have a system set up so that family members and friends can be notified, travel routes planned, and a bag packed and ready to go. You receive nutritional advice so you are in the best possible condition before and after surgery.

Is prior IVDU a reason to refuse a person a transplant? No.

How many people are on the waiting list for livers in BC? Eleven.

How many patients received livers last year? Twenty-four.

How many died waiting for a liver last year? Two.

What is the survival rate for Hep C transplanted patients?

85-90% survive one year.
80-85% survive five years.

Is the BC Transplant Society still transplanting patients with Hep C?

Yes. Nine of the twenty-four patients who received livers last year have hepatitis C.

Is multiple listing a possibility in Canada?

No. You cannot register for a transplant in another province. You must have B.C. residency to be placed in the transplant program in Vancouver. People all over B.C. may be accepted into the program, and they are flown into Vancouver when an organ becomes available.

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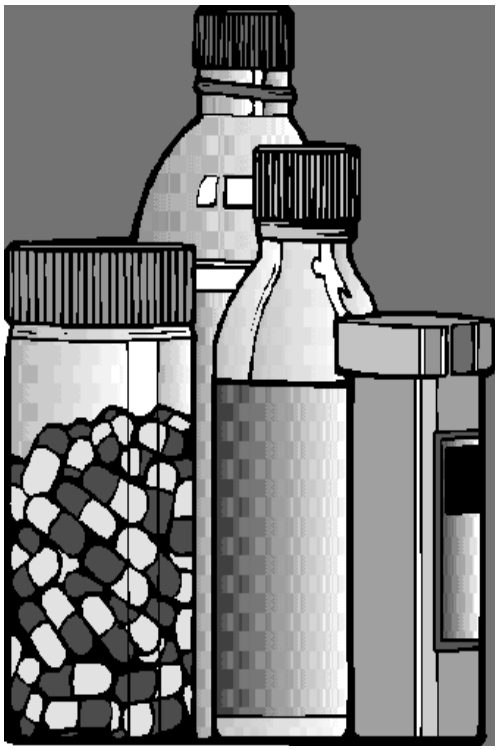
Alternative Treatment Helps

C.D. Mazoff

One of our members up-island has asked us to share some good news with you. Our friend, who has cirrhosis, had a blood test in August of 1998 which revealed AST-93, ALT-50 and a disturbingly low platelet count of 52.

After taking the following herbal extracts, CELA-M and CELA-2-M, under the supervision of a naturopath, blood tests in November 1998 revealed AST-50, ALT-23 and a platelet count of 81. He also feels great.



(MANSER—*Continued from page 3)*

all who have been deceived.

I suggest you step back and view the bigger picture—the crime that caused this holocaust and the continued negligence that is drawing out the suffering while putting others in danger. If you viewed the Fifth Estate, perhaps you now understand the level of crime we are dealing with and why these people will stop at nothing to cover it up.

Jo-Anne Manser

Editor's note: *We suggest that, if you are included in the 86-90 group, you consider consulting with a private lawyer before deciding to take part in the Class Action suit or choosing to drop out.*

(PAIN-*Continued from page 1)*

are probably the worst when the progression of the scarring of the liver has reached a point where portal hypertension exists. Basically the blood can't flow smoothly through the Portal Vein and it backs up. This causes a back pressure and in a worst case scenario you could see esophageal bleeds. If you couple that with an anti inflammatory, would it be possible to hasten the onset of a bleed?

If your physician has given you the go ahead on taking anti-inflammatories there are a few different kinds that can help guard against this problem.

First and foremost on the list is Pantoloc (Pantoprazole). It is a very powerful aid in preventing damage to the intestinal tract and in the resolution of duodenal ulcers. This medication is covered by Pharmacare *if* it is prescribed by a specialist. If your GP orders it, it may need pre-approval or it may not be covered at all. You'll need to check. 14 pills cost $34 but one pill covers the whole day. It is NOT for long term usage.

Other medications to protect the gut include Cytotec (Misoprostol) which decreases acid production and increases mucosal protection, and Sulcralfate (Sulcrat) which reacts with stomach acid to form a thick paste which adheres to the gut lining. One of the problems with these medications is that Cytotec can cause diarrhea initially and Sulcralfate can cause constipation in some individuals. Used as adjuncts to anti-inflammatory usage and for the very short term, the pros may outweigh the cons.

One new medication is Arthrotec which combines Cytotec and Voltaren (diclofenac) in a single tablet. This is paid for by Medicare with preapproval only. It is a costly drug if you have to pay for it out of your own pocket.

You can always go the other route and several brands of anti-inflammatories are available in suppository form. I find this is often my preferred route as you do not have to have a full stomach to take the medication whereas any of the oral medications require you to eat. Voltaren suppositories are available as is the generic and cheaper make Diclofenac. Indocid (Indomethacin) is also available in suppository form but this is a very strong and potentially damaging drug (even in this form).

Most of the anti-inflammatories are attached to sodium because it makes a very good delivery molecule. But the effect of this is often an upset in the fluid balance. This is particularly important, and one way to counteract that affect is by drinking lots of fluid. There is one anti-inflammatory that does not use sodium and that is Voltaren Rapide which uses potassium. It may not be covered by Pharmacare.

Finally—both the anti-inflammatories and Cytotec are excreted by the kidneys. Long term usage can show problems here. You can help to avoid that by drinking LOTS of water when you take these medications.

Just released in the US is a new generation anti-inflammatory which is called a COX 2 inhibitor. Celebrex (produced by Monsanto) received US FDA approval at the beginning of the year for treatment of both osteoarthritis and rheumatoid arthritis. COX 2 inhibitors are designed to be used as analgesics but do not have the gut damaging side-effects. I don't believe they are available in Canada at this time.

When the pain is from arthritis, it is often caused by muscles in spasm. It is possible that muscle relaxants may provide more relief than anti-inflammatories. The only one that I would talk with your physician about is Flexeril (cyclobenzaprine). This is not a benzodiazepine like Valium (diazepam) which is very addicting and also tends to tranquilize. However Flexeril is both metabolized and excreted primarily by the liver so you would want to discuss this very carefully.

Other drugs such as Elavil (amitriptyline) have also been found to be effective in some cases of Chronic Pain Syndrome and Fibromyalgia. It is usually sufficient to take an extremely low dose of this tricyclic antidepressant to obtain pain relief. This drug is extensively metabolized by the liver.

Non-drug therapies are the preference for people with liver disease. It may not be possible to get pain relief from an attack that comes up suddenly but it is something to work on long term and it can decrease the number of painful episodes. The Thorson Pain Clinic in North Vancouver and the Victoria Pain Clinic are two very excellent facilities. You need a referral to the North Van clinic, there is a long waiting list; but once you get in, there is no additional cost to you (above the user fee for massage therapy, etc). They attempt to break the pain cycle and to train you to respond differently to the pain such that it is not aggravated. Biofeedback, autogenics, creative visualization, and meditation are examples of the type of approaches that have proven effective in this way and are taught at the Pain Clinics. They also cover a multi disciplinary approach using massage therapy, physiotherapy, hypnotherapy, acupuncture, and rolfing to name a few. I spent a year at the Thorson Pain Clinic and found the techniques that I learned extremely helpful in pain control.

Hope is on the Horizon: Highlights from the Ottawa Conference

By Darlene Morrow

Hi Everyone

I just got back from the HCV Conference in Ottawa and I wanted to let you know the highlights of the meeting (which was fabulous).

First of all, I have to thank Jeremy Beaty for getting me an invite. The opportunity to be at this groundbreaking conference was due to his negotiations and involvement with the MRC and Health Canada.

I took two *books* of notes (!!!!) and will put it all in electronic form and on the web as soon as I have a chance.

This conference was unique because it not only involved the top hepatologists and gastroenterologists but also public health, CBS, epidemiologists, virologists, molecular cell biologists, psychiatrists, pediatrics and the list goes on. Of course all were specialized in HCV.

The highlights (in no particular order other than as my brain sees to it):

1. The CBS (Canadian Blood Supply) will be adopting PCR testing soon (in the next few months—I can't remember exactly but I have it written down).

2. The Nurses union had a meeting last weekend and have started a new specialty in hepatology. More help coming for us!!

3. Everyone recognizes the appalling lack of info on the part of GPs and Family Practitioners and a plan was proposed to get them up to snuff. Hallelujah.

4. There was a unanimous decision that networking is the only way to go and that the hepatitis community has been largely ignored and MUST be included in all aspects of the networking. ϑ They want *Centers of Excellence* across the country that can reach all communities including those that are isolated.

5. Only 25% of patients in specialists' practices are receiving combo therapy. And only 42% of these are responding—so in real numbers that is pretty pathetic. 40% of the patients are excluded due to having ALT levels that fall below the 1.5 criteria. There is a push to allow patients to make their own informed decisions. ϑ

6. Recognition that we MUST have more clinical trials coming to Canada to offer more treatment options especially for those people that relapse, etc. We must have fast tracking similar to the AIDS model to encourage drug companies to come to Canada.

7. Fatigue was recognized by *ALL* as being a major symptom of HCV and one that must be studied more. New tests that assess fatigue and quality of life must be HCV specific and get into much more detail.

8. Genotyping MUST be available for EVERY HCV patient. Anything less is providing substandard health care. The genotyping is necessary to make specific treatment recommendations e.g.—type 1b (they estimate that to be in the 85% range) must be treated for 1 year for the most favourable response and type 2 or 3 only need 6 months. I also stressed that this must not be done to exclude patients from treatment.

9. Long term follow up on responders to the combo is necessary to assess both the continued response and the long-term effect of the side effects (they have no idea what that will be).

10. Dental transmission was recognized. As were all forms of body piercing

Ponderables

by Lisa

Do infants enjoy infancy as much as adults enjoy adultery?

Why do women wear evening gowns to night clubs? Shouldn't they be wearing night gowns?

When someone asks you, "A penny for your thoughts," and you put your two cents' worth in, what happens to the other penny?

Why is the man who invests all your money called a broker?

Why is a person who plays the piano called a pianist, but a person who drives a race car not called a racist?

Why are a wise man and a wise guy opposites?

Why isn't 11 pronounced 'onety-one'?

"I am" is reportedly the shortest sentence in the English language. Could it be that "I do " is the longest sentence?

If lawyers are disbarred and clergymen defrocked, doesn't it follow that electricians can be delighted, musicians denoted, cowboys deranged, models deposed, tree surgeons debarked and dry cleaners depressed?

Do Roman paramedics refer to IV's as "4's"?

(**TRANSPLANT**-*Continued from page 4)*

Can I receive an organ from a donor with hepatitis C who may have a less-damaged liver?
This is being considered in Vancouver, although it hasn't been done yet. Kidneys have been transplanted into patients with hepatitis C from donors with hepatitis C. A donor with hepatitis C would have to have an undamaged liver, normal liver function tests, and would have had no recent illicit drug use or promiscuous behaviour. (This means some of us can be donors. Even if you can't donate your liver, you may donate skin, corneas, and bone. Sign up now!)

Are living donor transplants performed in BC?
Not yet. London, ON and Edmonton have done so in the case of a parent donating to a child, only.

A final word: Transplantation is *NOT* a cure for hepatitis C. The virus remains in the body and will probably re-infect and damage the new liver. Transplantation is only a treatment option. A patient must be healthy enough to survive 6 to 10 hours of surgery. After the surgery, anti-rejection drugs must be taken for life. The body is smart and knows when there is something foreign that it must attack, so the anti-rejection drugs trick the body into thinking that the new organ is not an intruder. The drugs have side-effects.

What can I do now?
Take care of your liver. Don't drink or expose yourself to toxins. Consider treatment. Sign up as an organ donor, and get your friends and family to do so as well. Forms are available at London Drugs and at all Motor Vehicle branches. Above all, let your family know that you wish to be a donor.

Information obtained from the UNOS website http://www.unos.org/, the TransWeb page http://transweb.org/ and from the kind help of Lynn Mori, co-ordinator of the BC Transplant Society in Vancouver, 1-800-663-6189.

(**TESTS**—*Continued from page 3)*
primarily nonspecific markers of necrosis (cell/tissue death) and inflammation, whereas alkaline phosphatase (AP), gamma glutamyl transpeptidase (GGT) and 5'-nucleotidase (5'-NT) are nonspecific indicators of cholestasis (stoppage or suppression of the flow of bile). The serum albumin level and prothrombin time (PT) reflect hepatic synthetic ability, but are too static to quantitate liver function. Likewise, the serum bilirubin level reflects prehepatic, intrahepatic, and posthepatic factors, making the differential diagnosis of jaundice complex. Of the available liver tests, only a handful such as the C-aminopyrine breath test and galactose elimination capacity (GEC) truly quantitate liver function.

AST
(Aspartate aminotransferase serum)

One of the two main liver function blood serum tests (the other being the ALT test). The purpose of this blood test is to detect a recent myocardial infarction (heart attack); to aid detection and differential diagnosis of acute hepatic disease and to monitor patient progress and prognosis in cardiac and hepatic diseases.AST levels by a commonly used method range from 8 to 20 U/L although some ranges may express a maximum high in the 40s. (Check with your physician.)

AST levels fluctuate in response to the extent of cellular necrosis (cell death) and therefore may be temporarily and minimally elevated early in the disease process, and extremely elevated during the most acute phase. Depending on when the initial sample was drawn, AST levels can rise—indicating increasing disease severity and tissue damage or fall—indicating disease resolution and tissue repair. Thus, the relative change in AST values serves as a reliable monitoring mechanism.

Maximum elevations are associated with certain diseases and conditions. For example, very high elevations (more than 20 times normal) may indicate acute viral hepatitis, severe skeletal muscle trauma, extensive surgery, drug-induced hepatic injury, and severe liver congestion. High levels (ranging from 10 to 20 times normal) may indicate severe myocardial infarction (heart attack), severe infectious mononucleosis, and alcoholic cirrhosis. High levels may also occur during the resolving stages of conditions that cause maximal elevations. Moderate-to-high levels (ranging from 5 to 10 times normal) may indicate chronic hepatitis and other conditions. Low-to-moderate levels (ranging from 2 to 5 times normal) may indicate metastatic hepatic tumors, acute pancreatitis, pulmonary emboli, alcohol withdrawal syndrome, and fatty liver (steatosis).

GGT
(Gamma glutamyltransferase)

The purpose of this blood serum chemistry test is to provide information about hepatobiliary

(Continued on page 8)

(**POLICE**—*Continued from page 4)*
salary but more importantly it presumes the disease was acquired on the job!

In November 1998, Senators Snowe and Snyder proposed legislation that would create a presumption that certain veterans contracted hepatitis C during their service. The legislation is to include veterans who, during their service, received tattoos, body piercings, or acupuncture. Depending what center you study the results from between 10 and 20% of veterans randomly tested - tested positive for hepatitis C.

Summary

In 1989, the hepatitis C virus was isolated and cloned. Yet, 10 years later most police departments have no protocol on how to deal with it and have offered no instruction to the officers on its prevention. In all known cases where it is believed police officers were infected on the job, they have been denied a disability pension. Employers are demanding proof that they were infected on the job.

If an officer chooses to disclose they are infected with hepatitis C, they are met with mixed response. Most co-workers choose to keep their distance—not clearly understanding routes of transmission.

Most officers choose to keep their infection to themselves—not telling anyone. They fear questions, ridicule, and a sense of guilt that remains unexplainable. It is as if somehow they allowed this nasty infection to invade their bodies.

7. Had the officer been shot or stabbed she would have received a hero's welcome back. Sadly, most are unaware of the moment of infection. Blood spat at an officer is innocently wiped away. Employers immediately have one answering questions, which sometimes have no answers. As with time, all memories seem to fade. Your employer starts asking personal questions, about *your* lifestyle. They doubt you and your words.

Even your doctor has more questions than answers. Doctors are undereducated and have difficulty coping with this emerging disease.

What are employers and doctors afraid of? Their own ignorance has caused this problem to mushroom among police officers and the effects will become clearly evident over the next 10 years as officers realize their infection and come to terms with chronic illness. What are employers doing to prevent the further spread of hepatitis C?

If you learn you are infected please:
1) get educated and help educate others
2) tell your co-workers—if you are injured on the job they will not think twice about helping out a downed officer.
3) wear a medic alert bracelet—you must be responsible for not spreading this disease to anyone.
4) use universal precautions everyday.
5) practice safe sex.
6) make yourself available to help fellow officers when they learn of their infection (peer counseling)
7) understand there are normal stages one passes through when their life flashes before them. Just because you have hepatitis C doesn't mean you will die. But you must understand there are steps you can take to remain healthy and possibly live longer. The sooner you are diagnosed the sooner you can change your lifestyle.
8) Stop drinking alcohol—it accelerates liver damage. Diet plays an important role in liver wellness. Learn about your liver and how to keep it in great shape.

Stages of Hepatitis C
1) Diagnosis - disbelief, shock, denial
2) Impact (Attitudes and Expectations) - learning to function with a chronic disease
3) Reorganization - dealing with the facts / lifestyle changes

One surefire way to reduce the emotional dilemma faced when an officer encounters a significant exposure is factual, up-to-date information. This is not simply an issue for the police officer but for the entire family.

It has been said the "C" stands for confusion, and so this tragedy continues.....

Regards,

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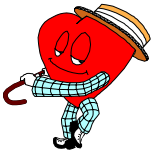

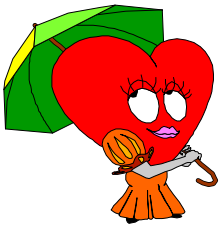

CUPID'S CORNER

This column is a response to requests for a personal classified section in our news bulletin. Here is how it works:

To place an ad: Write it up! Max. 50 words. Deadline is the 15th of each month and the ad will run for two months. We'd like a $10 donation, if you can afford it. Send checks payable to **HeCSC Victoria Chapter,** and mail to **HeCSC, Attn. Squeeky, 1611 Quadra St., Victoria, BC V8W 2L5.** Give us your name, tel. no., and address.

To respond to an ad: Place your written response in a separate, sealed envelope with nothing on it but the number from the top left corner of the ad to which you are responding. Put that envelope inside a second one, along with your check for a donation of $2, if you can afford it. Mail to the same address as above.

Disclaimer: The hepc.bull and/or HeCSC cannot be held responsible for any interaction between parties brought about by this column.

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A Hep C Story

Where to start? At the beginning! I am 38 years old. In 1988, at age 22, I had blood and platelet transfusions during emergency heart surgery and a series of operations on aneurysms that came up all over my body. The diagnosis? Endocarditis—most people don't live.

I did. I recovered enough over five years to rebuild something of a life again.

I knew I had hepatitis symptoms a month after getting out of the hospital. I was diagnosed with Non-A/Non-B hepatitis, which they renamed hepatitis C in 1989.

My GP at the time said, "You've nothing to worry about. It's just a hepatitis that you got from the blood work in the hospital. You had it and are now fully recovered. You have antibodies now. You'll always be a carrier but you won't have any symptoms."

I changed GPs in late 1992. I told the new doctor I had hepatitis C. He ordered blood work, and then told me exactly the same thing as the first GP, but added, "You can't pass it sexually or anything. You won't ever have any symptoms. You are just a carrier." He did one more round of blood tests in 1994, which he said were for the liver.

I went to him at least every six months, sometimes more, for Pap smears, etc., from 1992 until 1998.

He'd always ask, "Are you feeling are right?" I was better than I had been since my horrific 1988 illness. I managed retail stores, working 14 hours a day, 6-7 days a week. I was happy to start building a life again and having an income.

I went into property management in 1996. I loved it. I finally found my vocation—working 70 hours a week, enjoying every minute of it. I was doing well in every way except romantically. Even though both doctors led me to believe I could not pass it sexually, I felt obligated to tell prospective relationships I had it. That killed any romantic involvement.

I joined class action in 1996. They advised me that I was one of the ones with no symptoms, so settlement would be significantly smaller. I did not hang any hopes on settlement. I felt great, rising to be one of the top property managers in the company.

I was never phoned or contacted with results, so I assumed everything was still OK. In April, 1998, I went for a Pap smear and was told, "Your enzymes were slightly raised from the blood test in January. You should go to Dr. Anderson, a liver specialist, and have a liver biopsy."

I couldn't take this in during the appointment. I went back a week later and got into a large fight with him. I changed doctors that day. How could this be? I spent the summer reading everything I could, getting more and more worried, waiting for the specialist appointment in September, the earliest I could get in. I started taking herbs and vitamins, and my job began suffering. On the recent review of blood work done in blood tests—1992 through 1994—the AST level was twice normal range, as high as it was showing now. No GGT or ALT tests were done.

On October 16, 1998, a liver biopsy was performed. Dr. Anderson told me I'm in the last stages of cirrhosis grade 3-4. I also have autoimmune hepatitis, which has been destroying my liver. I was devastated.

I took steroids for eight months to try to stop it. I asked him if I had found this out years ago, could we have stopped the destruction to my liver? He said yes.

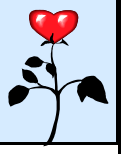
I asked him if I had found this out years ago, could we have stopped the destruction to my liver? He said yes.

Now I was fighting for my life. The whole life I had managed to build, I saw being snipped away. Besides the emotional and side effects from the steroids, I still had no symptoms.

I filed a lawsuit against the GP. How can these doctors treat people with such ignorance and lack of care? I may die before anything comes of it, but if it makes one doctor send one patient to a specialist because he admits he knows nothing about this horrible virus, it will do some good.

That is why I am writing to the newsletter. If I had felt lousy, I would have demanded to see a specialist, but in feeling great, I trusted this doctor to at least keep up with treatments and everything else to do with this virus. When he assured me I was fine, I believed him because I felt fine and wanted to put all illness behind me. This is a bitter lesson—and one that may be too late.

Pamela from Vancouver



(**TESTS**—*Continued from page 7)*

diseases, to assess liver function, and to detect alcohol ingestion. Another purpose is to distinguish between skeletal disease and hepatic disease when serum alkaline phosphatase is elevated. A normal GGT level suggests such elevation stems from skeletal disease.

Normal results in females under age 45, range from 5 to 27 U/L; in females over age 45 and in males, levels range from 6 to 37 U/L. Serum GGT values vary with the assay method used (colorimetric or kinetic). The sharpest increases in GGT levels indicate obstructive jaundice and hepatic metastasis. Elevations may indicate any acute hepatic disease, acute pancreatitis, renal disease, alcohol ingestion, postoperative status, and prostatic metastasis.

This test is nonspecific, providing little data about the type of hepatic disease. GGT is particularly sensitive to the effects of alcohol in the liver, and levels may be elevated after moderate alcohol intake and in chronic alcoholism, even without clinical evidence of hepatic injury.

CLASS ACTION SUITS:

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1-(888)-236-7797

Grant Kovacs Norell
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Before August 1, 1986
Klein Lyons
David A Klein
805 West Broadway, Suite 500
Vancouver, BC V5Z 1K1
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(604) 874-7180 (FAX)

also:

Dempster, Dermody, Riley and Buntain
William Dermody
4 Hughson Street South, 2nd Floor
Hamilton, Ontario L8N 3Z1
(905) 572- 6688

The toll free number to get you in touch with the Hepatitis C Counsel is 1-(800)-229-LEAD (5323).

ONTARIO AND OTHER PROVINCES

Pre 1986/post 1990
Mr. David Harvey
Goodman & Carr
200 King Street West
Suite 2300
Toronto, Ontario, M5H 3W5
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Fax: (416) 595-0527

TRACEBACK PROCEDURES:

INQUIRIES-CONTACT:

The Canadian Red Cross Society
4750 Oak Street
Vancouver, BC, V6H 2N9
1-(888) 332-5663 (local 207)

This information is for anyone who has received blood transfusions in Canada, if they wish to find out if their donors were Hep C positive.

CLASS ACTION/COMPENSATION

If you would like more information about class action/compensation, you can contact:
Trisha Plunkett Tel. (250) 479-5369
E-mail: *plunket@islandnet.com*

National Compensation Hotline
Tel. 1-(888) 780-1111