hepc.bull

BC's Hepatitis C News Bulletin

"Promoting HCV Wellness"

APRIL 2000 **Issue No. 22**

HCV AND THE HEART

By Kevin Donnelly

Hepatitis C is one of several micro organisms often associated with heart disease. The virus has been detected in myocardial tissue. The genome (the total set of genes carried by virus) was found in the heart muscle of a patient suffering hepatogenic myocardosis (inflammation of the heart muscle caused by the liver). Researchers suspect that the virus actually replicates in the myocardial tissue, so that the hepatitis C virus contributes to the development of an unusual form of myocarditis.

The virus was found in the hearts of some patients, and negative strands were also detected there. A high prevalence of HCV infection was found in patients suffering from hypertrophic cardiomyopathy, so it is suspected that HCV may be an important cause of this problem, when it is not hereditary.

In one study, myocardial fibrosis (scarring of the heart muscle) was found in all the patients, and some cellular infiltration was seen in 5 of those patients. Fifty-six percent of those patients had genotype 1b.

In another study, 2 of 3 patients had HCV in the ventricles, but not in the blood, suggesting that HCV may replicate in the heart muscle tissue and may be related to ventricular hypertrophy. HCV may play an important part in the development of hypertrophic cardiomyopathy.

In one report, the patient was suffering from severe type II cryoglobulinemia, probably related to HCV infection. (Cryoglobulinemia is a condition where substances in the blood called cryoglobulins "gel" when exposed to cold and then restrict blood flow.) The patient had a heart attack, due to exposure to the cold.

Cardiac abnormalities in hepatitis C patients include irregular heart beats as the most frequent problem. Interferon may make these symptoms worse.

These observations suggest that HCV infection is an important cause of a variety of otherwise unexplained heart diseases.

Medline Citations:

- HCV RNA was detected in myocardial tissue. PMID: 8651904
- We could identify the HCV genome in the myocardium of a patient with hepatogenic myocardosis. PMID: 10395090

(Continued on page 6)

HEPATITIS C AND THYROID DISEASE

By Will Lawson

During the past five years, several major studies have demonstrated links between hepatitis C (a chronic stimulus for the immune system) interferon (IFN)-alpha therapy, and thyroid gland disease, which can be considered a pretumoral condition.

Autoimmune Thyroid disease

In a 1997 study of 422 patients in Greece, all of whom had chronic viral hepatitis C, B, or D, 14.1 percent were found to have antithyroid peroxidase antibodies (ATPO), which are indicators of thyroid dysfunction. It did not appear to matter which hepatitis the subjects had, or whether they were male or female. However, females tended to be most severely affected and especially those with hepatitis C.

A 1998 study of 134 hepatitis C (HCV) patients and 41 hepatitis B (HBV) patients in Spain found that 4 percent of the HCV patients, but none of the HBV patients, had subclinical hypothyroidism before IFN-alpha treatment. The HCV patients also had significantly higher ATPO levels.

Tests done immediately after stopping IFN-alpha treatment showed that thyroid dysfunction had increased 9.7 percent, and hypothyroidism had increased 7.8 percent among the Greek patients, especially among those who had begun treatment with high ATPO levels. The rate of thyroid dysfunction among the Spanish HCV patients had increased to 12 percent, and among the HBV patients to 3 percent.

Six months after the end of treatment, the rate of thyroid dysfunction among the Greek patients had dropped to 8 percent. Thyroid function among the Spanish patients had normalized in 60 percent of those with HCV and in all of those with HBV.

A 1995 study of 588 Austrian patients treated with IFN-alpha found that 10 percent developed thyroid dysfunction during treatment. Patients having no pretherapeutic antibodies had a 7 percent risk of developing thyroid dysfunction during treatment. Females and patients with preexisting antibodies had an increased risk.

The combined conclusions of the studies were:

- for reasons not yet known, patients with chronic viral hepatitis on IFN-alpha treat-

(Continued on page 5)

CANADA PENSION PLAN DISABILITY BENEFITS

by Sheila Puga, Community Law Clinic, Vancouver

The Canada Pension Plan disability benefits appeal system: Part 2

I. Contribution requirements

The first thing that the Minister of Human Resources Development Canada considers when someone applies for any benefit under the Canada Pension Plan is whether that person has contributed enough to CPP to qualify for the benefit they are applying for. That is, the applicant must have contributed enough to CPP to meet either the minimum contribution requirements or the minimum qualifying period (MQP). [Section 44 (1)(b)(i) states that a disability pension shall be paid to a contributor who has made contributions for not less than the minimum qualifying period.]

If an applicant for disability benefits has not contributed enough to CPP (i.e., they do not meet the MQP), then it does not matter how disabled that person is, he or she will not qualify for disability benefits. Determining whether someone has contributed enough to CPP is not easy. The rules are complicated, and they vary depending on when the applicant became disabled. . . .

The first step in determining whether someone has contributed enough to CPP is to calculate the applicant's contributory period. Everyone who contributes to the Canada Pension Plan has a contributory period. Section 44(2)(c) of the Canada Pension Plan Act states that the contributory period begins on January 1, 1966, or when the contributor reaches the age of 18 (whichever is later), and ends in the month that the contributor is deemed disabled under section 44(1)(b). We reviewed section 44(1)(b) briefly in the last issue of CLM (*See also the* hepc.bull *#21)*.

To put this into context, if someone turned 18 before January 1, 1966, his or her contributory period still begins on January 1, 1966. The Canada Pension Plan did not exist before that date. Therefore, no contributions could have been made to CPP before January 1, 1966. If someone turned 18 after January 1, 1966, then their contributory period begins the year they turned 18. CPP does not collect any contributions before a person's 18th birthday.

Contributions are collected through an indi-

(Continued on page 3)

SUBSCRIPTION FORM

Please fill out & include a cheque made out to **HepCBC** - Send to:

HepCBC
2741 Richmond Road
Victoria BC
V8R 4T3

Name: _____

Address: _____

City: _____ **Prov**. ___ **PC**_____

Home(___)_____**Work**(___)_____

One Year Subscription: Donation **$10.00**

"I cannot afford to subscribe at this time, but I would like to receive the bulletin."

"I enclose a donation of $_____so that others may receive the bulletin."

Reminder: Any change of address, phone number or postal code, please let us ASAP
Tel. (250) 361-4808. hepcbc@pacificcoast.net

SUBMISSIONS: ***The deadline for any contributions to the* hepc.bull© *is the 15th of each month. Please contact the editors at hepcbc@pacificcoast.net, (250) 361- 4808. 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.

HOW TO REACH US:

PHONE:	***TEL: (250) 361-4808***
EMAIL:	***hepcbc@pacificcoast.net***
WEBSITE:	***www.pacificcoast.net/~hepcbc***
HepCAN List	***www.egroups.com/list/hepcan/***

HepCBC
2741 Richmond Road
Victoria BC V8R 4T3

REPRINTS

Past articles are available at a low cost in hard copy and on CD Rom. For a list of articles and prices write to HepCBC.

COMING UP IN BC:

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

Comox Valley Liver Disease Support Group Meetings: Third Tuesday of each month, 6-8 PM, St. George's United Church on Fitzgerald. NEXT MEETING: April 18th. Drop in daily for coffee. Contact: Ingrid or Nicky, 335-9167, nickyrussell@sprint.ca

Cowichan Valley Hepatitis C Support Contact: Debbie, 715-1307, mygirl@olink.net, or Leah, 748-3432, r._attig@bc.sympatico.ca

Downtown Eastside Hep C Support Group Meetings: Each Monday, 6 to 8 PM, Carnegie Center, 401 Main St., Vancouver. Contact Carolyn: momma@vcn.bc.ca

Enderby HepCURE Meetings: Last Sunday of each month, 2-4 PM, for High Tea, The Raven Gallery, 701 George St. NEXT MEETING: April 30th. Contact: Marjorie, 558-7488. www.junction.net/hepcure/index.html

HepCBC Hepatitis C Education and Prevention Contact: David, (250) 361-4808, hepcbc@pacificcoast.net

Kelowna HeCSC Meetings: Last Saturday of each month, 1-3 PM, Rose Avenue Education Room, Kelowna General Hospital. NEXT MEETING: April 29th. Contact: Michael, 860-8178, kelhepcsoc@mailcity.com or Elaine, 768-3573, eriseley@bcinternet.com

Kootenay Boundary Meetings: Second and fourth Tuesday of each month, 7 PM, 1159 Pine Ave. upstairs from Lordco auto parts. NEXT MEETINGS: April 11th and 25th. Contact: Brian, 368-1141, k-9@direct.ca or Pat, 364-1555

Mid Island Hepatitis C Society Meetings: Second Thursday of each month, 7 PM, Health Unit-Central Vancouver Island, 1665 Grant St., Nanaimo. NEXT MEETING: April 13th. Contact: Susan, 245-7654, hepc@nanaimo.ark.com, or Rose, 714-1937.

Mission Hepatitis C and Liver Disease Support Group NEXT MEETING: Contact: Patrick, 820-5576.

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: April 10th. Contact Dianne Morrissettie, 525-3790.

Parksville/Qualicum 201a-156 Morison Avenue, PO Box 157, Parksville, BC V9P 2G4. Open daily from 9AM to 4 PM, M-F. Contact: (250) 248-5551. dbamford@island.net

Penticton HeCSC Meetings: Second Wednesday of each month, 7-9 PM, Penticton Health Unit, Board rooms. NEXT MEETING: April 12th. Contact: Leslie, 490-9054, bchepc@telus.net

Powell River HepC Information and Support: Contact Cheryl Morgan for time and place info. 483-3804.

Prince George Hep C Support Group Meetings: Second Tuesday of each month, 7-9 PM, Health Unit Auditorium. Next Meeting: April 11th. Contact Sandra, 962-9630 or Ilse, ikuepper@pgrhosp.hnet.bc.ca

Prince Rupert Contact: April, 627-7083.

Princeton Meetings: Second Saturday of each Month, 2 PM, Health Unit, 47 Harold St. NEXT MEETING: April 8th. Contact: Brad, 295-6510, citizenk@nethop.net

Quesnel Contact: Elaine, 992—3640

Slocan Valley Support Group Contact: Ken 355-2732, keen@netidea.com

Sunshine Coast NEXT MEETING: Contact: Kathy, 886-3211. kathy_rietze@uniserve.com

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

Vancouver Support Group Meetings Last Wednesday of each month, 10:30-12:30, BC CDC Building at 655 West 12th (12th and Ash, next to the Cambie Street City Square Mall- park here) There will be someone outside the building to direct. NEXT MEETING: April 26th. Contact Darlene N., 608-3544, djnicol@attglobal.net, or Darlene M., 608-3544, hepcvsg@canada.com

Vernon HepCURE Contact: Marjorie, 546-2953 for Hep C information.

Vernon HeCSC HEPLIFE Meetings: Second and fourth Wednesday of each month, 10 AM-1 PM, The People Place, 3402-27th Ave. NEXT MEETINGS: April 12th and 26th. Contact: Sharon, 542-3092. sg-grant@home.com

Victoria HeCSC Meeting: Last Wednesday of each month, 1-3 PM and 7-9 PM, NEXT MEETING**:** April 26th. Contact: 388-4311, hepcvic@idmail.com for possible new location.

OTHER PROVINCES

Central Alberta CLF Hepatitis C Support Group Meetings: Second Thursday of each month, 6-8 PM, Provincial Building, Room 109, 4920 51 St., Red Deer. Enter at southeast entrance. NEXT MEETING: April 13th. Contact Shane, 309-5483.

Durham Hepatitis C Support Group Meetings: Second Thursday of each month, 7-9 PM, St. Mark's United Church, 201 Centre Street South, Whitby, ON. NEXT MEETING: April 13th Contact**:** Jim 743-0319, tndrhart@idirect.com or Smilin' Sandi smking@home.com, http://members.home.net/smking/

Edmonton, Alberta Hepatitis C Informal Support Group Meetings: Third Thursday of each month 6-8 PM, 10230-111 Avenue, Edmonton, Conference Room "A" (basement) NEXT MEETING: April 20th, Contact: Tracey Peddle, NitNGale@telusplanet.net or Jackie Neufeld: 939-3379 Parking: Meter Parking (underground and surface) roughly $3 per evening. Free street parking.

Hep C Niagara Falls Support Group Meetings: Last Thursday of each month, 7-9 PM, Niagara Regional Municipal Enviromental Bldg., 11684 Sodom Road. NEXT MEETING: April 27th Contact: Rhonda, 295-4260

Hepatitis C Society of Ottawa-Carleton Centertown Comm. Health Center, 420 Cooper St. (Ottawa) between Bank and Kent St. We offer one on one peer counselling Mon. afternoons. NEXT MEETING: April 11th. Contact: 233-9703 or sue.rainville@sympatico.ca

Kitchener Area Chapter Meetings: Third Wednesday of each month, 7:30 PM, **Cape Breton Club, 124 Sydney St. S., Kitchener**. NEXT MEETING: April 19th. Contact Carolyn, 893-9136

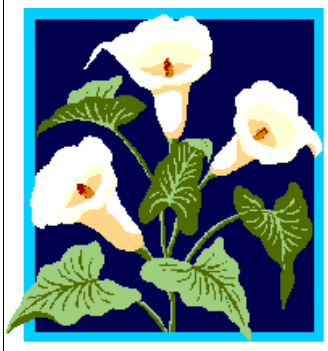
SQUEEKY'S CORNER

MESSAGE FROM THE PRESIDENT

If you've been following the *hepc.bull*, you will remember that HepCBC incorporated last May. In the meantime, board members have come and gone, the overall situation seems to have stabilized, and things are starting to move ahead. HepCBC and HeCSC have now separated, no longer share Board/ Steering Committee members or office space, and HepCBC has taken full responsibility for the *hepc.bull*, for the HepCAN list, and for the printing and distribution of Peppermint Patti's FAQs. Because, at present, we have no funding other than that generated by subscriptions and donations which have begun to trickle in, in order to cut costs, we are mailing out newsletters only to those who have subscribed. Many subscription fees mailed in during the last few months never reached the coffers of HepCBC, but we are honouring those subscriptions anyway.

On a more positive note, I'm very pleased with the Board, of which I have been elected President. Everyone is working hard to make this work. Eventually we hope we can bring together all the various support groups in BC, to provide a unified voice when necessary, and to share resources. This month we held a strategic planning meeting, with David Milligan from the Ministry of Finance facilitating. The meeting was very well attended and David did an excellent job.

We need volunteers to distribute our pamphlets and FAQs, to help fold and stuff the newsletter, to form committees to plan social events and educational blitzes, etc. To that end, we have placed a membership form here in the newsletter. PLEASE HELP!



On the calendar is a Music Marathon on Sunday, April 30, at the Church of Truth, 111 Superior, Victoria, at 8 PM. The well-known Jazz/Klesmer group "Dumka," from Pagliacchi's, has kindly offered to play and organize local musicians from the Victoria Symphony and friends to provide an unforgettable evening of entertainment, proceeds going to HepCBC. The tickets will cost $10.00 each. Don't miss it! We hope to see you there.

Joan King

HEP C RISK FACTORS

Based on a 1997 study of 758 people with hepatitis, principal risk factors were found to be as follows:

IDU
Blood transfusion in non-IDU
Sex with an IDU
Having been in jail more than 3 days
Religious scarification
Having been stuck or cut with a bloody object
Pierced ears or body parts
Immunoglobulin injection

The number of sex partners and intranasal drug use were not statistically important, taking into account other risk factors.

Source: Hepatology 2000 Mar;31(3):756-76, Risk Factors for Hepatitis C Virus Infection in United States Blood Donors.Murphy EL, Bryzman SM, Glynn SA, Ameti DI, Thomson RA, Williams AE, Nass CC, Ownby HE, Schreiber GB, Kong F, Neal KR, Nemo GJ University of California San Francisco, San Francisco, CA. PMID: 10706569

Order Your FAQ's Now

More of Peppermint Patti's FAQ are now available. The new version includes an HIV co-infection section as well as updated Canadian Links. Place your orders now. Over 100 pages of information for only $2 each plus S&H—but if you can afford more we'll take it. Contact HepCBC at (250) 361-4808, or at the address on page 2, "How to Reach Us."

THANKS!!

HepCBC acknowledges the personal donations, donations in kind received to date, and the following for discounts, donations of services, or equipment: The BC Ministry of Health, Steve Orcherton, Fernwood Home Services, Kiwanis, CFAX 1070, AM 900, CompuSmart, BC Transit. We also wish to acknowledge the generosity of the residents of VIRCC, Uncle Dave, the law firm Woods Adair, D. Putsey, John and Shirley Hiley, Cassandra McColm, Christina M. Reid, and some wonderful anonymous donors. Additional thanks to Margison Bros. Printers, Jerry DeWit, Paul Hyatt, Alex Olson & David Milligan.

(CPP DISABILITY—*Continued from page 1)*

vidual's employment or self-employment income. The contributory period ends in the month that the minister considers the applicant to have become disabled - using the CPP definition of disabled. Once you have determined what the applicant's contributory period is, you can determine whether he or she meets the minimum contributory requirements or the MQP.

II. The minimum qualifying period

In the past, the minister would only calculate whether the applicant met the MQP at the time that he or she applied for disability benefits. In other words, the minister would assume that the person applied for CPP disability benefits immediately after becoming disabled, and would conclude that the contributory period ended on the date the person applied for benefits. But if the applicant waited to apply for disability benefits, the minister often found that he or she no longer had sufficient CPP contributions to meet the MQP.

Late applications. In June 1992, the federal government introduced Bill C-57, which included a "late application" provision. The late application provision is now in section 44(1)(b)(ii) of the Canada Pension Plan Act. This section allows the minister to determine when the applicant last met the MQP in cases where the applicant does not apply for disability benefits right away. This allows applicants who do not apply immediately after becoming disabled (when they stop working) to have their applications considered if they can demonstrate that they were indeed disabled when they last met the MQP. Without section 44 (1)(b)(ii), people who did not apply shortly after becoming disabled would not qualify for disability benefits because of insufficient CPP contributions.

The MQP tests There are three different contributory tests for CPP disability benefits, depending on when the applicant became disabled.

Between January 1, 1966 and December 31, 1986

If the applicant became disabled between January 1, 1966 and December 31, 1986, he or she must have made valid contributions to CPP:

a) in 5 out of the last 10 years of the contributory period; and
b) in either 1/3 of the entire contributory period or in 10 years.

The applicant must meet both of the above tests to fulfill the MQP. To determine a), calculate the last 10 years of the contributory period (the years immediately before the end of the contributory period). Within those 10 years, the applicant must have contributed to CPP in at least 5 years. To determine b), calculate the entire contributory period (from beginning to end). Count the total number of years in this period. Then determine the number of years that the applicant contributed to CPP during this period. Using these 2 figures, you should be able to determine whether the applicant made contributions in at least 10 years, or in at least 1/3 of the entire contributory period.

Example: John Smith applied for CPP dis-

(Continued on page 5)

THE CO-INFECTION SECTION

HIV/HCV Co-Infected Patients Have Faster Liver Fibrosis Progression Rate Than HCV Positive Patients Without HIV *Average time to liver cirrhosis (scarring) was 26 years in co-infected patients, 8 years sooner than HCV positive patients without HIV, by Harvey S. Bartnof, MD* **(Reprinted with permission from HIV and Hepatitis.com (www.HIVandHepatitis.com)**

Due to similar routes of transmission, an increasing number of patients with either HIV or HCV (hepatitis C virus) are co-infected with both viruses. As widespread use of HAART (highly active antiretroviral therapy) has occurred in developed countries, co-infected patients increasingly are dying due to complications of HCV and not HIV disease.

Previous studies have shown that HIV/HCV co-infected patients have a higher rate (up to 3-fold) of liver cirrhosis (scarring) than HCV positive patients without HIV. However, these studies were retrospective with smaller numbers of patients and only examined the co-factors of age, sex (gender) and route of infection. Those studies did not look at the co-factors of age at infection or alcohol consumption. (These latter factors are associated with progression in patients infected only with HCV.) Similarly, these studies did not distinguish between the factors of liver fibrosis and "necroinflammatory" scores, two markers of disease extent on liver biopsy. Also, the effect of HAART had not been considered. Now, researchers have examined such co-factors in 122 (29% women) HIV/HCV co-infected patients from France and compared them to a control group of 122 patients infected only with HCV. The report was recently published in the journal Hepatology.

Patient Background and Baseline Information

HCV positive patients in the study were from the Liver and Gastroenterology Department at Hospital Pitit-Salpetriere in Paris, France. HCV tests were positive for both antibodies and RNA viral load. HCV positive patients were excluded if there was no baseline liver biopsy, there was a positive test for hepatitis B surface antigen (indicating dual HBV/HCV infection), or if the date of HCV infection was not known. . . . .

The mean age in both groups was 35 years. Injection drug use was the route of HCV transmission for 90%, with transfusion of blood or blood products for the remaining 10%. The mean duration of HCV infection was 13 years in both groups. (The date of first using injection drugs was considered to be the year of HCV infection, since studies have shown that 90% of persons do become HCV-infected within the first year after starting.) The mean daily alcohol consumption was 57 grams in the co-infected group and 50 grams in the HIV mono-infected group (no significant difference). In the co-infected group, 33% drank more than 50 grams daily, compared to 28% in the mono-infected patients (no significant difference) . . . .

How is the 'Fibrosis Rate' Determined?

The fibrosis (scarring) progression rate (FPR) was measured by using the following formula. The mean baseline liver fibrosis score * (scale of 0-4) was divided by the estimated duration of HCV infection. For example, if someone had a fibrosis score of F2 and had been infected with HCV for 8 years, then the FPR would be 2 / 8 = 0.25 fibrosis units per year. Then, different patients could be compared in terms of how fast they develop liver disease-this correlates with liver illness symptoms and death from liver disease. This method was first described by one of the report's co-authors, Thierry Poynard, MD in 1997 in the journal Lancet. If there are two liver biopsies in different years, then the fibrosis score used is the score from the first biopsy subtracted from the score on the second biopsy. Then, that score is divided by the duration of HCV infection. This latter method is considered to be more accurate than the first one with only one biopsy. However, many patients prefer not to have multiple liver biopsies. In the current study, 12 of the HCV/HIV co-infected patients had two liver biopsies.

Results

Among the 122 patients in the HIV/HCV co-infected group, there was information available about anti-HIV therapy for 110 of them (90%). Among those 110 patients, 74 or 67% were taking anti-HIV therapy. Twelve (11%) were taking HAART that included a protease inhibitor plus 2 NRTI (nucleoside reverse transcriptase inhibitor) drugs for 12 months before the liver biopsy. Another 48 (44%) were taking only two NRTI drugs for 33 months. Similarly, 14 (13%) were taking only one NRTI drug for 30 months. (Note many patients began clinic visits before triple anti-HIV therapy was standard for HIV.)

The results were as follows. Significantly more HIV/HCV co-infected patients (60%) had abnormal fibrosis scores * (F2, F3, or F4) than the HCV mono-infected patients without HIV (47%). Similarly, significantly more co-infected patients (54%) had higher "necroinflammatory" ** scores (A2 [moderate] or A3 [severe]) than their HCV mono-infected counterparts (30%).

The mean fibrosis progression rate (FPR) in the HIV/HCV co-infected patients was significantly higher (0.18 fibrosis units per year) than it was in the HCV mono-infected patients (0.13 fibrosis units per year). This would mean that the average (median) time until cirrhosis (time to a fibrosis score of F4) in the HIV/HCV co-infected group was 26 years (range 22-34 years). This compared to an average time to cirrhosis in the HCV mono-infected group of 34 years (range 32-47 years).

Interestingly, the fibrosis rates were somewhat different among the co-infected patients, depending upon their anti-HIV therapy. Even

(Continued on page 6)

TREATMENT

IL-10 MAY HELP NON-RESPONDERS

Interleukin (IL)-10 is a cytokine, a hormone-like protein substance produced by our bodies, like interferon. It affects the formation of liver fibrosis. A study was done to determine the effect of the substance on the damaged livers of 24 patients with hepatitis C, non-responders to interferon therapy. Biopsies were performed before and after treatment, which lasted 90 days. The treatment was well tolerated and 22 patients completed the study. Five of the nineteen patients who normalized ALT levels sustained the response, and the liver biopsies showed improvement, but there was no antiviral effect. This may be a good treatment for interferon non-responders.

GASTROENTEROLOGY 2000;118:655-660 Interleukin 10 Treatment Reduces Fibrosis in Patients With Chronic Hepatitis C: A Pilot Trial of Interferon Nonresponders, DAVID R. NELSON, et al, University of Florida College of Medicine, Gainesville, FL; and Department of Antiviral Therapy, Schering Plough Research Institute, Kenilworth, NJ

DEMYELINATING POLYNEUROPATHY

Demyelinating polyneuropathy is an autoimmune disorder which has been found rarely in Hep C patients after interferon therapy. In this disorder, there is swelling of nerve roots and destruction of the covering of the nerves, causing weakness or paralysis, and difficulty moving, especially the arms and legs. Numbness, tingling, and burning sensations may also be present.

Conventional treatment includes Prednisone and other corticosteroids. One post-interferon patient was treated with a single, extended course of plasma exchange, resulting in a complete, sustained remission.

This disease may be caused by allergies, so it is important to try to identify those allergies, and possibly try desensitization therapy. Detoxification therapy may be helpful, but should be used with caution in hepatitis patients, under the supervision of a doctor.

Sources: Muscle Nerve 2000 Mar;23(3):433-435 Chronic inflammatory demyelinating polyneuropathy after treatment with interferon-alpha. Meriggioli MN, et al, Rush-Presbyterian and Chronic Inflammatory Demyelinating Polyneuropathy at http://www.medical-library.net

CLINICAL TRIALS

CLINICAL TRIALS PIPELINE

This site is dedicated to tracking clinical trials all over the world. Check it out:

http//www.frontiernet.net/~monty/hcvpipel.html

Anti-HCV Ribozyme Trials

Ribozyme Pharmaceuticals, Inc. (RPI) has begun a Phase I clinical trial of LY466700, an anti-hepatitis C virus ribozyme which acts like "molecular scissors," cutting out HCV in a special manner. The phase I study will test the safety and side-effects in normal volunteers. The second study will consist of trials on people infected with Hep C who have never received treatment of any kind. This chemical is designed to attack the Hep C virus and stop it from replicating. It is expected to be effective will all the known genotypes. LY466700 seems to work even better when it is combined with interferon.

Source: PR Newswire Wednesday February 16 8:02am Contact: Daniel McCue of Freeman McCue Public Relations, 714-557-3663, for Ribozyme Pharmaceuticals

ISIS 14803 Trials

Isis Pharmaceuticals is starting clinical trials with ISIS 14803, a newl antisense drug to treat Hepatitis C. This study will evaluate safety and efficacy in this Phase I/II trial, patients receiving the drug intraveneously in 2-hour infusions three times a week for 4 weeks. Studies of the subcutaneous delivery of ISIS 14803 will follow. Subsequently, studies of ISIS 14803 using a microfusion pump, will be initiated. In preclinical studies, ISIS 14803 demonstrated specific reduction of the HCV RNA expression in both cell cultures and mouse model systems.

March 1 /PRNewswire/ via NewsEdge Corporation

(**CPP DISABILITY**—*Continued from page 3)*
ability benefits in August 1988. He claims that he became disabled in June 1984, when he was 42 years old. His Record of Earnings shows valid contributions to CPP for the following years: 1972, 1973, 1975, and 1979 - 1984. Has Mr. Smith contributed enough to CPP to qualify for disability benefits?

Answer: First, determine his contributory period. It starts in 1966, since his 18th birthday would have been before January 1, 1966. Assume that it ends in 1984, when he became disabled.

The first part of the test requires us to determine if he has made valid contributions in 5 out of the last 10 calendar years. He would have to have contributed to CPP for at least 5 years - from 1975 to 1984 (inclusive). Since Mr. Smith has 7 years of contributions between 1975 and 1984, he meets the first part of the test. However, he must also meet one of the two tests set out in paragraph b).

The second part of the test involves looking at the entire contributory period. He must have contributed to CPP for either 10 years in the entire contributory period OR in at least 1/3 of the years of the entire period. Since Mr. Smith has 9 years of contributions, he has contributed to CPP during at least 1/3 of the entire contributory period (9 years of contributions out of 19).

In fact, Mr. Smith will continue to meet the MQP until the end of 1986. Therefore, if the medical evidence does not support his claim that he became disabled in 1984, but it does support a conclusion that he became disabled sometime in 1986, he would still meet the MQP (since he would still have contributions in 5 out of the last 10 years of his contributory period, and in 1/3 of the total contributory period).

Between January 1, 1987 and December 31, 1997 If the applicant became disabled between January 1, 1987 and December 31, 1997, the applicant must have made valid contributions to CPP: a) in 2 out of the last 3 years of the contributory period; or b) in 5 out of the last 10 years of the contributory period.

This contribution test is much easier to meet than the pre-1987 test. In fact, an applicant only needs to meet one of the two tests.

Example: Using the previous example, does Mr. Smith qualify for disability benefits after December 31, 1986?

Answer: Yes. In fact, Mr. Smith will continue to meet the MQP until December 31, 1989. Mr. Smith has made valid contributions to CPP in 5 years between 1980 and 1989. In this case, count Mr. Smith's last five years of contributions: 1980, 1981, 1982, 1983, and 1984. In order to meet the 5 out of 10 test, determine the tenth year from 1980, which is 1989. The end of that calendar year is when Mr. Smith last meets the MQP.

In calculating when the applicant last meets the MQP, when the applicant claims to have become disabled is not necessarily important. All you need to do is determine when the applicant last contributed enough to CPP to actually qualify for benefits. In Mr. Smith's case, as long as you can find medical evidence that supports the conclusion that he was disabled (as defined by the legislation) before December 31, 1989, he will be eligible for disability benefits.

On or after January 1, 1998

If the applicant became disabled on or after January 1, 1998, he or she must have made valid contributions to the Plan:

a) in four of the last six years of the contributory period; or

b) in each year after the month in which the applicant stopped receiving a previous disability benefit.

This test, found in section 44(2)(a) of the act, is more difficult to meet than the pre-1998 test. An applicant who became disabled before January 1, 1998, and who had only contributed to CPP in two years could be eligible for disability benefits under the pre-1998 test, above. However, an applicant who became disabled on or after January 1, 1998 will have to have at least four years of contributions to receive disability benefits.

In addition, the pre-1998 test gives applicants an opportunity to meet one of two tests (a or b). The current test really only sets out one test (a). The applicant must have at least four years of contributions in the last six years of his or her contributory period or he or she will not qualify for benefits. The test in b) only applies in situations where a disability benefits recipient goes off the benefits, presumably to return to work, and then re-applies. Before January 1, 1998, applicants would have to meet one of the two pre-1998 contribution tests to re-qualify. They would have to have contributed to CPP for at least two years after returning to work to re-qualify for disability benefits.

Under the current test, the applicant must have contributed to CPP for each year after he or she stopped receiving previous disability benefits. This may make it easier for some people to re-qualify for the disability benefit, and more difficult for others.

III. The Record of Earnings

The Record of Earnings records all of an individual's contributions to the Canada Pension Plan. Referring to this document is the easiest way to determine when someone contributed to CPP.

The Record of Earnings Summary is set up as a table, and indicates the years in which the applicant made contributions to either the Canada Pension Plan or the Quebec Pension Plan. The table has five columns. The first column lists the years in which the individual contributed to CPP. It will never include any years before 1966, when CPP was introduced.

The second and third columns are labelled "CPP CONT" and "QPP CONT," respectively. These columns show the contributions the applicant made to either the Canada Pension Plan or the Quebec Pension Plan. The fourth column is labelled "UPE." UPE stands for "Unadjusted Pensionable Earnings," and shows the amount of the contributor's earnings from which contributions to CPP were calculated. The figures in the last column are administrative codes.

To determine whether the applicant has a valid contribution for any given year, look at the UPE column. Generally, if a number appears in that column, the applicant probably has a valid contribution for that year. If the UPE amount is indicated as "00000," then the applicant did not have sufficient earnings from which a CPP contribution could have been assessed, even if a number appears in either the CPP CONT or QPP CONT columns. Although it may appear that the applicant contributed to CPP in a year with no UPE earnings, that contribution was probably refunded on the applicant's tax return. Once you have identified all of the years that have valid contributions, you can determine if the applicant meets the relevant MQP test.

(**THYROID**—*Continued from page 1)*
ment exhibit an almost threefold increase of baseline thyroid dysfunction, persisting long after the end of therapy;

- the factors that increase the risk of thyroid dysfunction are female gender, a decrease in average serum level of free triiodothyronine after trial initiation, and positive serum levels of thyroid peroxidase antibodies before therapy;
- in many patients there is no need to stop treatment with IFN-alpha nor to treat the thyroid dysfunction specifically; and
- thyroid function and thyroid antibodies should be evaluated for free thyroxin (FT4) and thyroid-stimulating hormone (TSH) levels before the start of IFN-alpha treatment, and every four months during and after treatment, or for the high risk groups, every two months.

Thyroid Cancer

Thyroid cancer is suspected but not proven to be another possible harmful complication caused by chronic HCV infection.

In 1999, Italian researchers concluded a thyroid study of 139 HCV patients, comparing them to 835 non-patients who lived in an area with a relatively high incidence of thyroid disorders. Of the 29 HCV patients discovered to have a thyroid disorder, three had thyroid cancer. Two of them had been treated with interferon-alpha. None of the non-HCV patients had thyroid cancer.

Sources:

Fernandez-Soto L, et al, Increased risk of autoimmune thyroid disease in hepatitis C vs. hepatitis B before, during, and after discontinuing interferon therapy. *Arch Intern Med 1998 Jul 13;158(13):1445-1448*

Weissel M, et al, Universitätsklinik für Innere Medizin III, Wien, Interferon-alpha-induzierte Störungen der Schilddrüsenfunktion, *Acta Med Austriaca, 22: 1-2, 1995, 1-5*

Uchida, K., MD, et al, Kanazawa Medical University, Painless Thyroiditis Occurring During Long-Term Interferon, *Vol. 89, Southern Medical Journal, 01-01-1996, pp 81.*

Fernandez-Soto, Dr. Luisa, et al, Universitary Hospital, Granada, Patients infected with the hepatitis C virus (HCV) are more susceptible to autoimmune thyroid disease, *Arch Intern Med 1998;158:1445-1448.*

Deutsch, Melanie, et al,., Thyroid Abnormalities in Chronic Viral Hepatitis and Their Relationship to Interferon Alfa Therapy, *Hippokration General Hospital, Greece, AASLD*

Antonelli, Alessandro, MD, et al, University of Pisa, Letter To the Editor: Thyroid Cancer in Patients With Hepatitis C Infection, *Research Letters - May 5, 1999, JAMA*

NOT JUST THE LIVER

During the year 1996, 321 patients with an average age of 46, infected with hepatitis C virus (HCV), took part in a study to investigate other symptoms of the virus other than those associated with the liver, and to compare the results with those of people co-infected with HIV. Thirty-eight percent (122/321) of patients presented at least 1 symptom not related to the liver.

Clinical extrahepatic manifestation:
Joint pain (60/321, 19%)
Skin problems (55/321, 17%)
Dry mouth (40/321, 12%)
Dry eyes (32/321, 10%)

Main biologic abnormalities were:
Mixed cryoglobulins (110/196, 56%)
Clotting problems (50/291, 17%)
Autoimmune problems—presence of the following autoantibodies:
antinuclear (123/302, 41%)
rheumatoid factor (107/280, 38%)
anticardiolipin (79/298, 27%)
antithyroglobulin (36/287, 13%)
antismooth muscle cell (27/288, 9%).

Four parameters were significantly associated with **cryoglobulin positivity:**
Systemic vasculitis [inflammation of small blood vessels]
HIV positivity
Rheumatoid factor positivity
Sicca syndrome

A definite connective tissue disease was noted in 44 patients (14%), mainly symptomatic mixed cryoglobulinemia and systemic vasculitis.

HIV coinfection (23%) was associated with 3 parameters:
Anticardiolipin
Thrombocytopenia
Arthralgia/myalgia

HIV-positive patients presented more severe histologic lesions ($p = 0.0004$).

Extrahepatic clinical manifestations in HCV patients involve primarily the skin and joints.

Source: Extrahepatic manifestations associated with hepatitis C virus infection. A prospective multicenter study of 321 patients. Medicine (Baltimore) 2000 Jan;79(1):47-56, Cacoub P, et al Department of Internal Medicine, Hopital La Pitie-Salpetriere, Paris, France. PMID: 10670409, UI: 20135305

***(Co-infection** Continued from page 4)*
though the differences were not statistically significant, there were some clear trends. (The reason for the non-significance likely is due to small numbers of patients in each group.) The slowest fibrosis progression rate (FPR) was among the co-infected patients taking HAART, 0.10 fibrosis units per year. A somewhat faster rate was among co-infected patients taking only two NRTI drugs, 0.17 fibrosis units per year. An even faster rate occurred among co-infected patients taking only one anti-HIV drug (one NRTI drug), 0.2 fibrosis units per year. No patients were taking a non-NRTI drug.

What might be initially surprising to some was the fact that co-infected patients not taking anti-HIV therapy had a progression rate that was slower (0.14 units per year) than those taking double NRTI drug therapy (0.17 units per year). This could be due to the fact that some of the anti-drugs can cause liver toxicity-this occurs more frequently among those infected with hepatitis virus(es). The negative of anti-HIV drug toxicity might be outweighed by the benefits of HAART that includes a protease inhibitor. However, the numbers of patients in each group are rather small. Also, adherence rates were not reported. These two factors also might explain this seemingly paradoxical result This research group has already presented a report showing that protease inhibitor combination therapy for HIV is associated with a slower liver fibrosis progression rate among patients co-infected with HIV/HCV.

Using a statistical "multivariate analyses," each of the following factors were independently associated with a faster liver fibrosis progression rate in HCV positive patients: (1) HIV infection; (2) drinking more than 50 grams of alcohol daily; (3) age at the time of HCV infection of 25 years or older; and (4) immune suppression, as designated by a CD4 count less than 200 cells per microliter. Among pa-

(Continued on page 7)

ST. JOHN'S WORT WARNING

TheNaturalPharmacist.com advises that, although safe while taken by itself, St. John's wort may be dangerous when taken with other medications, and may even be lethal, according to articles in the February 12, 2000 issue of *Lancet*. Studies began in 1998, and further causes for worry were found last spring at the Annual Congress for Clinical Pharmacology in Berlin, where it was announced that St. John's wort interferes with the heart drug digoxin and the blood-thinning drug warfarin (Coumadin). Since even slight changes in the activity of these two medicines may cause serious problems, possible interactions with St. John's wort may possibly be dangerous. Other dangerous combinations include St. John's wort with:

—protease inhibitors used for treatment of HIV infection.
—cyclosporine.
—oral contraceptives.

There is at present a good system to detect possible dangerous interactions between drugs, but not between herbs and drugs. If in doubt about any natural medicines, check with TheNaturalPharmacist.com (http://www.tnp.com), an interactive Web site, directed by a team of physicians and pharmacologists. *[Editor: This is a GREAT site!]*

***(HCV and the Heart** Continued from page 1)*

- Microorganisms that are frequently associated with heart disease, including cytomegalovirus, hepatitis B virus, hepatitis C virus. PMID: 10530439
- Myocarditis: These findings suggest that HCV replicated in myocardial tissue of these patients with myocarditis. Thus, HCV infection may contribute to the development of this unusual form of myocarditis. PMID: 9236410
- Myopathy: HCV RNAs were found in the hearts of patients with cardiomyopathies, and negative strands of HCV RNA were also detected in the hearts, suggesting that HCV replicates in myocardial tissues. PMID: 10078023
- Detection of HCV-Specific Sequences in Chronic Myopathy with Hepatitis C. PMID: 10529547
- The importance of (HCV) infection has been recently noted in patients with cardiomyopathies. PMID: 10078023
- Hypertrophic Cardiomyopathy -HCM: A high prevalence of HCV infection was found in patients with HCM, particularly of the apical variety, suggesting that HCV is an important causal agent in the pathogenesis of the disease. PMID: 10406581
- Apical hypertrophic cardiomyopathy and hepatitis C virus infection. A high prevalence of HCV infection was found in patients with HCM, particularly of the apical variety, suggesting that HCV is an important causal agent in the pathogenesis of the disease. PMID: 10406581
- The familial form of hypertrophic cardiomyopathy (HCM) is attributed to mutations in the genes for contractile proteins, but the etiology of non-familial form remains unknown. PMID: 10406581
- Myocardial fibrosis was found in all patients, and mild cellular infiltration was observed in 5 patients. Type 1b HCV RNA was present in the sera of 5 of the 9 [56%] patients. PMID: 10406581
- In two of these three [66%] patients, HCV RNA was detected from biopsy and autopsy specimens of the ventricles, but not in the serum, suggesting that HCV may replicate in myocardial tissue and may be relevant to ventricular hypertrophy. PMID: 8651904
- Thus, HCV infection may play a role in the development of hypertrophic cardiomyopathy. PMID: 8651904
- **Type - II CG (Cryoglobulinemia):**
- Severe type II cryoglobulinemia after ten years of asymptomatic (HCV) infection is reported. Laboratory data showed hypergammaglobulinemia with polyclonal IgG and monoclonal IgM, blood hyperviscosity, high level of cryocrit (60%), HCV viremia, and normal levels of serum transaminases. Due to cold exposure, acrocyanosis and cardiac ischemic attack occurred. PMID: 8915697
- **Dilated Cardiomyopathy – DCM:**
- 1996 - Hepatitis C virus infection is frequently found in patients with dilated cardiomyopathy and that hepatitis C virus is an important causal agent in the pathogenesis of the disease. PMID: 8951578
- 1995 - Hepatitis C virus infection is frequently found in patients with dilated cardiomyopathy and that hepatitis C virus is an important causal agent in the pathogenesis of the disease. PMID: 7586353
- **HCV Cardiac Observations:**
- Various cardiac abnormalities were found, and arrhythmias was the most frequent. PMID: 9626910
- Changes of 24-h Holter monitor recordings in association with interferon alpha therapy for chronic hepatitis C. PMID: 9852725
- These observations suggest that HCV infection is an important cause of a variety of otherwise unexplained heart diseases. PMID: 9626910

Ref PM: http://www.ncbi.nlm.nih.gov/PubMed/

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 cheques payable to **HepCBC,** and mail to **HepCBC, Attn. Squeeky, 2741 Richmond Road Victoria BC V8R 4T3.** 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 cheque for a donation of $2, if you can afford it. Mail to the address above.

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

Ad No. 10

Respectful, respectable man (49) but looks younger who is very active and loves life. I'm 6' tall, 210 lbs. and considered nice looking, emotionally and financially secure and non-symptomatic. I won't let Hep C rule my life and am looking for a positive female to share a long-term happy life together. Vancouver area.

Ad No. 16

Attractive, healthy, working male seeks female companion and/or roommate 28-38 yrs. Newly renovated 2 bedroom house. Great kitchen, garden, yard, etc. Fernwood area in Victoria

To: The Directors
HepCBC Hepatitis C Education and Prevention Society
2741 Richmond Road
Victoria, B.C.
V8R 4T3

APPLICATION FOR MEMBERSHIP

I hereby apply for membership in the HepCBC Hepatitis C Education and Prevention Society.

Enclosed is my cheque in the amount of $10.00 payable to HepCBC in payment of my membership fee for the year 1999/2000. I understand that the enclosed membership fee is for the year ending July 31, 2000, and that you will advise me when the membership fee for the following year has been set by the directors.

I understand and agree that every member of the Society must uphold the Constitution and Bylaws of the Society.

Dated the day of , 2000.

_____
Signature of Applicant

Applicant's Name: _____
(Please Print)
Address: _____

_____

Postal Code: _____

Telephone No: ( ) -
Fax No: ( ) -
E-mail address: _____

[ ] I cannot pay at this time. Please waive my membership fee.
[ ] I enclose $_____ to cover another person's membership fee.
[ ] I enclose $_____ donation.
[ ] I would like to be contacted to do volunteer work.

IS IT WORTH IT?

Letter from Michael

Dear Joan and Dave,

Life at the present is quite a bit better now that I was given a new lease on living. By that I mean I had a liver transplant on January 15, 1999. The hardest part is sticking to the strict regime of taking medications three times per day for the rest of my life. The psychological aspect of dealing with a new liver is not an easy proposition for anyone to endure. Depression is the largest aspect to deal with in my daily life. There are so many questions one asks oneself. Is it all worth it? I have to ask myself every day. I answer, YES, it is. By the way, I acquired Hep C Sept 28, 1975. Talk to you later.

Michael in Kelowna

***(Co-infection** Continued from page 6)*

tients co-infected with HIV/HCV, each of factors (2), (3), and (4) above also were significantly associated with a faster progression of liver fibrosis. Interestingly, gender (sex) was not a significant co-factor. Due to the fact that only 35% of the patient participants had HCV genotyping, that co-factor was not considered in the analyses.

The authors then combined factors in a worst case and best case scenario for patients co-infected with HIV/HCV. If a co-infected patient has a CD4 count less than 200 cells per microliter and drinks more than 50 grams of alcohol daily, the median time to cirrhosis (fibrosis stage F4) is only 16 years. This was due to a high FPR of 0.25 fibrosis units per year. Whereas, if a co-infected patient has a CD4 count greater than 200 cells per microliter and drinks less than 50 grams of alcohol daily, the median time to cirrhosis is much longer at 36 years. This is due to their much slower FPR of 0.1 fibrosis units per year. Note that a 36 year time to cirrhosis in this situation is almost the same as the median time to cirrhosis of 38 years in HCV mono-infected patients (without HIV and without considering alcohol consumption). The authors also calculated that the longest time to cirrhosis was among HCV mono-infected patients, without HIV, who did not drink any alcohol, 40 years.

Overall, these numbers suggest that co-infected patients who maintain a CD4 count higher than 200 cells per microliter (with HAART) and who drink less than 50 grams of alcohol daily will not develop cirrhosis significantly faster than HCV mono-infected patients. Moreover, if co-infected patients taking HAART are able to benefit by also taking anti-HCV therapy, their time to cirrhosis might be even longer (studies are underway). A few small studies have shown that co-infected patients with CD4 counts that are only slightly low (early HIV disease, without HAART) respond to anti-HCV therapy nearly as well as HCV mono-infected patients without HIV. . . . . .

Note from the editors: This excellent study goes on to list some of its limitations and provides a complete bibliography. Unfortunately we have had to cut the article and omit some of the more technical discussion due to limitations of space. Should you wish to view the article in its entirety please go to www.HIVandHepatitis.com)

CHANGE OF ADMINISTRATORS

By Joan King

On March 9, Superior Court Justice Nicole Morneau fired the proposed Hep C compensation fund administrator, probably causing tainted blood victims to wait months more for their money. Crawford Adjustors Canada of Kitchener has been appointed, instead of Navigant Consulting/Peterson Worldwide, to administrate the $1.2-billion fund. Both companies are based in the U.S. One of the worries was Navigant's lack of bilingual services and offices in Canada. It is also involved in 10 class action suits in the US. Navigant has said it will do everything in its power to cooperate so that the turnover will go smoothly. Crawford Adjustors will take over the responsibility for providing application forms, aiding in preparing claims, reviewing eligibility, approving claims, and handing out cheques.

Source: Anxiety deepens for Hep-C victims, CP OTTAWA, Friday, March 10, 2000

Happy Passover

LOOKING FOR YOUR RECORDS

By Bruce DeVenne

As many of you have found out, the health systems that oversaw the blood have destroyed, lost or can't find a large portion of the papers pre-'86 and, in some cases '86-'90. Here are a few things you can try to solve this problem.

- First, the hospitals all have blood banks, or blood banks in the large area hospitals, from which they draw supplies. Contact that blood bank and ask that they check their computer and, if necessary, written or microfiche files for your records.
- Second, go to the hospital where you received, or suspect you received, the blood, and arrange to see all your files. If you were given blood, a copy of the paper work off each unit should be attached to you file, and as well, the unit numbers should be handwritten into the records.
- Third, contact the RCMP blood task force and ask them to go after your records. Neil Vandusen was told his records were no longer there, and later on, the RCMP called him, asking questions. They had located his files via a search warrant.

If the Blood Services are stonewalling you, let me know at bdevenne@sprint.ca or call me at 1-902-864-6376. This seems to be a recurring problem with the CBS, and is one that has got to stop.

If you are outside the window and planning to sue, you will have to prove that you were infused and that the blood was contaminated. Even if all you can do is prove that you were infused, this will help.

HELP US HELP YOU

By Dave Lalonde

I was so glad to have seen Jarad Gibbenhuck stand up in front of 100 people attending Hep C day at Carnegie Community Centre on March 4th, 2000. What a remarkable display of courage and fortitude from such a frail young man, to tell his story.

This inspired me to encourage you to rise up off your tired, collective butts and contact the media, politicians, and RCMP Blood Task Force. Tell your story before it's too late.

The lawyers have had ample time and opportunity to do it right, but their efforts fall way short. Their self-serving interest stops at the bank.

The Canadian Blood Services have lost sight of what is most important, that is, to restore faith and trust in a flawed blood supply system. Call them and demand your traceback results, so you can get on to the next hurdle. I suspect they are already done and simply await an administrator to further confuse procedural issues.

When I called CBS to obtain results for my wife, Sharon, they first contacted Dr. Graham Sher, Vice President of CBS, for advice before returning my call within the hour. He then phoned me the following day, at 6:15 PM Ontario time from his cellular to appease my concerns. He subsequently sent me a letter outlining the cornerstones of confidentiality, the accuracy and sensitivity of their testing, and refused to provide donor samples to my physician or anyone else for alternate testing. On a political level, when questioned by Mr. Ted White, MP, and Mr. Reed Elley, MP, Dr. Sher dismissed them with mere copies of the letter he sent me.

These politicians, and the RCMP Blood Task Force, want to hear from you telling your story. My suspicions may very well be a cornerstone in the walls of Jericho.

Please help them help you!

Sincerely,
D.J. Lalonde

PS: The CBS claim to privacy/secrecy is not inherent, nor is it a law.
Email: Dave&Sharon@telus.net

HepCBC Musical Benefit

Sunday, April 30
The Church of Truth
111 Superior, Victoria, at 8 PM

Featuring
The well-known eclectic-ethnic ensemble

Dumka

Plus
Guest Appearances by Members of
The Victoria Symphony
Island Chamber Players

Tickets $10 ***Call 361-4808***

CLASS ACTION SUITS:

BRITISH COLUMBIA

Camp Church and Associates
Sharon Matthews / Kim Graham
4th Floor, Randall Building
Vancouver, BC V6B 1Z5
1-(888)-236-7797

Grant Kovacs Norell
Bruce Lemer
Grosvenor Building
930-1040 West Georgia Street
Vancouver, BC, V6E 4H1
Phone: (604) 609-6699 Fax: (604) 609-6688

Before August 1, 1986 or 1990-1991
Klein Lyons
David A Klein
Legal Assistants: Lisa Porteous and & Candace Wall
1100 - 1333 West Broadway, Vancouver, BC V6H 4C1
(604) 874-7171 or 1-(800) 468-4466
(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
Phone: (416) 595-2300
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 me:
Leslie Gibbenhuck Tel. (250) 490-9054
E-mail: bchepc@telus.net
Anyone who has started a lookback and wants it completed, let me know. I need your name, address, birth date, transfusion dates, and traceback number and they have guaranteed us they will move on it right away!!!

National Compensation Hotline
Tel. 1-(888) 726- 2656