hepc.bull

BC's Hepatitis C News Bulletin

"Promoting HCV Wellness"

SEPTEMBER 2000 **Issue No. 26**

RED CROSS DEAL FOR THOSE OUTSIDE WINDOW

Source: TORONTO, Aug. 3, 2000, CNW-- "Red Cross Makes $79 Million Available to Transfusion Claimants," and, Toronto Star, August 4, 2000, Tracey Tyler "`Forgotten' blood victims ponder $79-million deal."

The Canadian Red Cross will be using $79 million it has recovered from the sale of its assets to set up a trust fund to help approximately 5,400 people who have claims for health problems caused by Canada's blood system in the past. Those eligible include a group of about 25 people infected with HIV through blood transfusions in the early 1980s, and a larger group of hepatitis C sufferers outside the 1986 and 1990 window. The money also includes contributions from insurers and co-defendants. About 1700 commercial creditors are being asked to accept partial payment for the debts owed them, and Red Cross staff and offices have been cut back to help get claimants a fairer offer, according to one of the negotiators.

An Information Circular that describes the Plan is being mailed to those who have filed blood-related claims against the Canadian Red Cross, and to commercial creditors. Those people will vote on the Plan on August 30, 2000, and, if accepted, the blood-related lawsuits against the Canadian Red Cross will be dropped.

Claims from commercial creditors under $10,000 would be settled in full and claims for more than $10,000 would be settled on the basis of 67 cents on the dollar.

"On behalf of the Red Cross and its Board of Governors, I offer our deepest apology for the suffering and hardship that has resulted for many people," said Pierre Duplessis, Secretary General of the Canadian Red Cross, in a letter to creditors and claimants. "We know that the amounts that will be distributed to claimants under this Plan will not provide full or adequate compensation in many cases. It is with compassion that we say it is the best we can do. However, committed as we are to meeting claims fairly, we

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ANGRY? WHO, ME?!!!

By Joan King

I don't know about you, but I've never run into a group of "unreasonably" angry people in my life like some of those I have encountered in Hep C support groups, both "live" and on the internet. Don't get me wrong. Some of these people are my best friends, but I can't but help feeling there is some sort of physiological connection there. And to be fair, I'll even include myself. Have you felt yourself reacting in a way that you **know** is illogical? I sure have, especially before treatment. I did a search on the internet to see what I could find.

Indeed, I found several sources that linked anger with a diseased liver, and the sources were both holistic and medical. The holistic view is that anger is a negative emotion that can get stuck in the liver, especially a liver that isn't functioning well.

The medical point of view is that hepatic encephalopathy, or brain and nervous system damage caused by liver disorders, can cause changes in consciousness, behaviour, and personality. It can even cause coma. It can also cause forgetfulness, confusion, disorientation, delirium, dementia, loss of memory, intellect, reasoning, changes in mood, decreased alertness, daytime sleepiness, progressive stupor, decreased ability to care for oneself, loss of small hand movements, muscle tremors, seizures, speech impairment, a strange musty odour to the breath and urine, and, well, you get the idea. An EEG will show characteristic abnormalities, and blood tests can confirm this phenomenon. No, it's not your imagination.

No wonder we're angry! The severe symptoms are usually experienced only with cirrhosis, but two research groups have recently reported that HCV can affect the brain in people with less advanced disease, even with mild fibrosis. This disorder was not just related to hepatic encephalopathy. In an Austrian test comparing 58 healthy

(Continued on page 6)

KLEIN IN VICTORIA

Mark your calendars: David Klein will be speaking on **September 19th at the Eric Martin Pavilion Theatre of the Royal Jubilee Hospital in Victoria, from 2 to 5 PM.**

If you wish to come, try to let us know in advance. Please leave a message at 361-4808.

David A. Klein is counsel for the British Columbia pre-1986 class action. He is also the court appointed representative counsel for the British Columbia pre-86/post-90 transfusion claimants in the Red Cross insolvency proceedings.

David will speak about the recently released Red Cross Plan of Compromise and Arrangement and he will give an update on the class action that is continuing against the federal and provincial governments.

David Klein is a partner with the Vancouver law firm Klein, Lyons where he specializes in personal injury law and class action litigation.

CAPT. KEVIN DONNELLY

Kevin Donnelly, a US Vietnam veteran and contributor of original articles to the *hepc.bull* and FAQ, died suddenly on Aug. 4th, due to complications of hepatitis C, before we got to thank him enough for all he has done. He was a vital part of our community, with his research and activism, and will be sorely missed.

His family sends thanks to the Hep C community for flowers, card, and memorials, and ask that we honour him by uniting to promote awareness of hepatitis C.

"PADDY" KIELEY

Patrick (Paddy) Kieley passed away on May 16, 2000 as a result of liver failure. He is survived by his wife Beverly and a number of children. He was formerly of Cape Breton and leaves a number of relatives there. He was 59.

SUBSCRIPTION/ MEMBERSHIP 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**(____)_____

Email: _____

☐Membership + Subscription (1 year): **$20.00**

☐Membership Only **$10.00**
(for those already receiving the bulletin):

☐Subscription Only **$10.00**
(for those already members of HepCBC):

☐"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."

SUBMISSIONS: ***The deadline for any contributions to the* hepc.bull© *is the 15th of each month. Please contact the editors at info@hepcbc.org, (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***
FAX: **(250) 414-5102**
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WEBSITE: ***www.hepcbc.org***
HepCAN List ***www.egroups.com/list/hepcan/***

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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.

NOTE FROM THE EDITORS: It has been correctly brought to our attention that the STATS from last month's hepc.bull, comparing Hep C infection to AIDS infections, would be more accurate if they compared ESLD (End Stage Liver Disease) to AIDS, or Hep C to HIV infections. As soon as we have these statistics we will print them here.

Peppermint Patti's FAQ Version 4 Available NOW!!

Peppermint Patti's FAQ Version 4 is now available. The new version includes an HIV co-infection section as well as updated Canadian Links and the latest TREATMENT INFORMATION. Place your orders now. Over 100 pages of information for only $5 each plus S&H—but if you can afford more we'll take it. Contact HepCBC

THANKS!!

HepCBC would like to thank the following institutions and individuals for their generosity in the form of grants, personal donations, donations in kind, discounts, and donations of services, or equipment: Elsevier Science, Blackwell Science, Massachusetts Medical Association, Health Canada, The Legal Services Society of BC, The BC Ministry of Health, Pacific Coast Net, BC Transit, Rick Wiertz, Alfred & Muriel Evans, Margison Bros Printers and Island Collateral. Special thanks go to Miss Danielle Creally for helping with the bulletin

NEW VICTORIA WOMEN'S SUPPORT GROUPS

let's get together for tea. For more information call Joan: 595-3882

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. 17

Attractive, young middle aged male 6'2," 180 lbs. Caring, compassionate, spiritually focused, very outdoors oriented, professional artisan, massage therapist. Loves canoeing, hiking, camping, old movies, beach barbecues. Hep C pos./minimal symptoms. Would love to meet similar adventurous woman for outings, friendship, potential life partner. Vancouver Island.

SINGLE? LONELY?

Alberta Hepatitis Singles web
http://clubs.yahoo.com/clubs/albertahepatitissingles

Got HepC?... Single?
...Visit
http://clubs.yahoo.com/clubs/ontariohepcsingles
We can't fix the Hep.. but we can help make sure you're not alone..
Drop by and say hello ...

SQUEEKY'S CORNER

Point

Dear C.D. Mazoff!

Well, this is the third time I have attempted to respond to your letter … what with handing out free needles and barring ordinary citizens from entering the premises.

I must assume that somewhere along the line you came across something informing you that the current target of AIDS serving organizations (ASOs) is IDU's. It would appear that you were also mislead into believing that IDU's are the only population ASO's would serve and that harm reduction is the only strategy employed in working with that population.

You will be pleased to hear that while for most ASO's injection drug users and harm reduction strategies are part of our work, we do indeed serve many populations through a variety of strategies. In fact, the mandate of the organization I work with is:

"The Bulkley Valley AIDS Society is a non-profit society that works in the North West to provide HIV/AIDS and Hepatitis C education, information and training along with care, support and advocacy for and with people living with HIV, AIDS and hepatitis C, and their families, friends, and loved ones."

Seems broad to me.

Specifically, I would be happy to share our detailed hepatitis C work plan with you because I believe it is important that we are accountable to the folks who matter most in all this. The short story is that the project works with people who have HCV to develop a support network here in the northwest, starting at the community level and works also to increase the level of understanding and awareness about Hep C in the general population and within the medical and health care professions. This is a three-year project. The coordinator position fades out over the final 2 years, leaving community funds available for projects identified by communities themselves, with the support of the project. If you would like a copy of our work plan, please let me know and I will send you one.

I want to assure you that we are not and will not be assessing people's involvement with the project by how they became infected.

Additionally, we are in the process of finding a new name for our society to reflect that we work regionally and that we work with HIV and Hepatitis C.

Just as an aside, I am intensely curious about this - do we know that tax payers and IDU's are always mutually exclusive groups?

Finally, I want to say for myself that I feel truly honoured to have the opportunity to serve on this project and I hope that I can do it the justice it deserves.

I would be happy to continue this reasoned, thoughtful conversation with you anytime; perhaps I will even have the pleasure of meeting with you sometime. I truly mean that

In friendship,

Deb Schmitz
Project Coordinator
North West Regional Hepatitis C Community-Based Support Project.

Editors' note: Indeed, we have since met with Deb and had a profitable and friendly talk.

Counterpoint

It seems to me that despite the insight and eloquence of the accompanying letter, the writer still fails to understand the nature of my argument.

So I thought I would talk about a few of these "ordinary citizens," just to refresh our memories:

First there's Mrs. L, who was taken from her husband unexpectedly after she was transfused with HCV. Mr. L, a man of increased years who has fought for all of us, has tried unsuccessfully to get the government to acknowledge the cause of his wife's death on her death certificate, so that they might both rest in peace. Mr. and Mrs. L, despite their years of service to this country, were not deemed worthy of an answer or consideration by our political system.

Next, there's Mrs. F, who having been transfused outside the 86-90 window by a matter of months, will most likely not see a penny. She has been very ill, has had to fight at great personal cost for her rights and has not gotten very far. She had to pay for IFN treatment out of her own pocket, which not only just about bankrupted her, but also caused very serious kidney damage, the medicines for which the government will not pay.

As well, there's Mr. FG who, despite his years of service to this country, has been forced through incredible hoops to get his Canada Pension, although he is just at the point of end stage liver disease. Mr. FG is very ill, but he has been told by the system that he is not.

I cannot mention enough the confusion and heartbreak of the victims and their families who, having been poisoned by the government, now find themselves abandoned and abused.

Mr. D and Mrs. T have been told that they never had transfusions, although there were witnesses. Both have cirrhosis, and both are quite ill. All records have been successfully destroyed and they have been told to shove off. To further complicate matters, Mrs. T's husband has abandoned her and left her with 4 children.

These ordinary citizens have fought for this country; their taxes have built our roads, our schools, our public utilities. And yet they get less recognition and social benefits than those who might mug them in between fixes!

Recent reports on the healthlines indicate that HCV infection among healthcare workers is severely underreported, that there are present dangers in the beauty and dental industry, that emergency response teams, firefighters and veterans have high percentages of infection.

What programs have the Federal and Provincial governments put in place to address the above issues? Little to none in my opinion. Instead, they have poured a very large sum of money into a population group that many elderly and more conservative citizens would consider as undeserving of such preferential treatment.

Don't get me wrong! I'm very happy that Deb is dedicated to helping all people with HepC, she seems very competent, and quite caring. I have no doubt that the Bulkley Valley project will accomplish much.

It is not that I object to funding outreach medical services to the disadvantaged among us; it's just that I'd like to broaden the definition of this category so that it is applied more equitably in this democratic country of ours

Sincerely,

Dr. C.D. Mazoff
Executive Director HepCBC

CLINICAL TRIALS

LY 466700

Source: PRNewswire/ July 21, "RPI Receives $1 Million Milestone From Lilly in Anti-Hepatitis C Ribozyme Collaboration"

Ribozyme Pharmaceuticals, Inc. reported last May that in single dose safety trials their anti-Hepatitis C ribozyme, LY 466700 appeared to be well tolerated in un-infected volunteers, and trials have begun in Hep C patients to study safety and tolerability in a 28-day regimen. There are 20 patients involved in this new trial. Ribozyme Pharmaceuticals is located in Boulder, CO.

4-YEAR "HALT-C" STUDY FOR NON-RESPONDERS

Source: National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). The HALT-C Trial information sheet, distributed at Digestive Disease Week 2000; May 21-24, 2000; San Diego, California.

Improvements in the condition of the liver have been noted in non-responders as well as in responders. One study showed that continuing IFN may maintain those improvements in non-responders, and reduce progression to liver cancer, so researchers will see if non-responders taking Pegasys for 3 ½ years will slow their progression. The enrolment will take place at 10 clinical centres in the US, starting this summer. Hopefully this trial will be brought to Canada, as well.

After 20 weeks of Pegasys plus ribavirin, non-responders will receive weekly Pegasys or no treatment for 3 ½ years. Responders will not be eligible for the second part of the study.

To be eligible, patients must be over 18, positive for antibodies and virus after taking IFN or IFN + ribavirin. They must have an increase of either ALT or AST 6 months before enrolment, and must have at least stage 3 fibrosis using the "Ishak" scoring system. They must be willing to use contraception. Patients with any of the following will not be accepted: Other liver disease; Child-Turcotte-Pugh score of 7 or more points; history of ascites, encephalopathy or esophageal bleeding; platelets < 75,000 per litre; neutrophil counts < 15000 per litre; hematocrit < 33%; alphafetoprotein > 200 ng/ml; bilirubin > 2.5 mg/dl; serum creatinine > 1.5 mg/dl; HIV; poorly controlled diabetes; any other serious medical disorder; a serious psychiatric disorder; alcohol abuse within the past year; use of illicit drugs within the past 2 years; intolerance to previous IFN; inability to understand and agree to the study; pregnancy, breast feeding or the male partner of a pregnant woman; unwillingness to have 3 biopsies.

PEGASYS + MAXIMINE TRIALS

Source: Reuters Health, "Maxim, Roche partner on combination therapy for hepatitis, cancer" by Kate Fodor, Aug 11, 2000

Maxim and Roche plan to conduct two phase III studies of the combination therapy for hepatitis C, starting late this year or early next, for naïve and non-responder patients. The two firms are not trying to create a product that combines the drugs. They are trying to gain approval for their joint use.

Preliminary results from a phase II study suggest that combining Maxamine and IFN-alpha can produce a complete viral response in 69% of patients, compared with 29% or less with IFN alone.

If Pegasys is approved, it would be "the only pegylated form of interferon for the treatment of chronic hepatitis C which has been specifically tested and shown to be safe and effective in patients whose disease is complicated by liver cirrhosis," according to the company.

Thymitaq Phase III Trials

Source: PRNewswire/ via NewsEdge Corporation, "Phase III Trials to Begin for Zarix's Thymitaq," Aug. 9, 2000

Thymitaq(R), a thymidylate synthase inhibitor by Zarix, Inc., is a new cancer drug compound that is being developed to treat several different cancers, especially liver cancer. The US FDA has just approved a Phase III trial for the treatment of inoperable hepatocellular carcinoma (liver cancer). The study will be conducted in the U.S., Canada, Europe and South Africa. Over eighty-five clinical trial sites are currently being evaluated for participation in the pivotal trial. Patient enrolment should begin in early fourth quarter 2000. Thymitaq(R) was granted 'Fast Track' status by the FDA in April. The company expects completion of patient enrollment for the liver cancer trial in eighteen months, with completion of the trial in twenty-four months and release of the results from this trial six months later.

http://www.zarix.com

(**DEAL**—*Continued from page 1)*
are also dedicated to sustaining the Red Cross as a viable organization in Canada and across the world."

"If you're dying of a disease that is as serious as Hep C is, and you've never been given anything, you're pretty desperate and you'll take the money, I guess," said our own Mike McCarthy, vice-president of Canadian Hemophilia Society.

For further information: Bob Rae, (416) 597-6255; André Doren, Canadian Red Cross, (613) 740-1927, www.redcross.ca

THE CO-INFECTION SECTION

CO-INFECTED PATIENTS HAD A DECREASED ABILITY TO INCREASE CD4 COUNTS AFTER ACHIEVING HIV RNA VIRAL UNDETECTABILITY, WHEN COMPARED TO HIV MONO-INFECTED PATIENTS

by Harvey S. Bartnof, MD

HCV co-infection significantly increased HIV disease progression after anti-HIV therapy was started in 1,157 patients (34% women) when compared to 1,954 patients with HIV mono-infection who started treatment. The large Swiss cohort included an observation period of more than four years.

The proportion alive and without clinical progression after three years of treatment was 80% among HIV/HCV co-infected patients who continued injecting drugs, 85% among HIV/HCV co-infected patients who stopped injecting drugs and 90% among those who were only infected with HIV and not injecting drugs. Those differences were highly statistically significant.

Co-infected patients had a 1.7 "relative hazard" of AIDS progression or death when compared to HIV-mono-infected patients in a "regression (statistical) analysis" that included other potential co-factors. HCV viral loads did not appear to be a co-factor. Interestingly, co-infected patients had a decreased ability to increase CD4 counts after achieving HIV RNA viral undetectability, when compared to HIV mono-infected patients. Types of anti-HIV therapy (HAART versus no-HAART, highly active antiretroviral therapy) were not reported. HIVandHepatitis.com will present a more expanded review of this interesting poster within 10-14 days. The lead author was G. Greub, MD from the University Hospital in Lausanne, Switzerland. Previously, there had been conflicting reports about the effects of HCV infection on HIV progression in co-infected patients. Conversely, several studies have shown that without HAART and a CD4 response, HIV infection accelerated HCV disease in co-infected patients.

Reference:

Greub G and others. Negative impact of HCV infection on HIV progression, survival and immune restoration in the Swiss HIV cohort studies. Abstract and poster presentation MoPeB2139 at the XIII International AIDS Conference; July 9-14, 2000; Durban, South Africa.

Source: hivandhepatitis.com 07/11/00

MANAGEMENT OF HEPATITIS C

Source: Journal of Gastroenterology and Hepatology 15 (s2), E164-E171 : Sk Sarin, Management of Hepatitis C: What should we advise about adjunctive therapies, including herbal medicines, for hepatitis C?

In this well researched and up-to-date article, Dr. Sarin presents an overview of different approaches to standard treatment of hepatitis C Acknowledging the less than desirable response rates achieved through IFN mono and combo treatment, as well as the inability of many patients to tolerate ribavirin, Dr. Sarin discusses the important adjuvant therapies that have been evaluated in the past 5 years.

URSODEOXYCHOLIC ACID (UDCA)

No unusual side-effects were observed by combining UDCA and IFN; the treatment was well tolerated. One of the disadvantages of adding UDCA could be that this drug may reduce the ALT levels by itself and may give a false-positive response when HCV RNA may still be present, so monitoring of the response of the drug using only biochemical indices (e.g. ALT) could pose problems, and viral monitoring is preferred.

Based on the currently available data, there is little justification in recommending UDCA together with IFN to treat patients with chronic hepatitis C.

IRON REDUCTION THERAPY

Excess liver iron has been alleged to be directly responsible for causing liver damage. A reduction in the amount of iron in the liver is known to delay the progression of liver scarring. Iron may increase replication of HCV indirectly by decreasing T cell function or it may directly promote the replication. Moreover, excess liver iron has been associated with a lower response to IFN in patients with chronic Hep C. Therefore, in the past few years, many investigators have attempted to lower the iron levels in the blood and deplete the total body and liver iron levels.

There are two approaches to reducing blood iron levels (i) phlebotomy (blood-letting) and (ii) a low iron diet.

Phlebotomy

In two studies, the effect of phlebotomy was assessed in 40 and 16 patients, including treatment-naïve patients and non-responders to IFN. A reduction in serum iron levels was associated with lower ALT levels, suggesting that excess iron may have a role in cell death in chronic hepatitis C.

In several other studies, phlebotomy has been combined with IFN. **It was apparent that non-responders to IFN had significantly higher serum or hepatic iron levels than the responders**. However, the usefulness of phlebotomy together with IFN and ribavirin has not been evaluated so far.

Low-iron diet (*see also page 8 of this issue*)

Increased absorption of iron from the gut, especially in patients with chronic liver disease, is an important mechanism for iron overload. A low-iron diet is mainly a milk and plant-based vegetarian diet, which provides only 5.1 mg/day of iron compared with a normal diet that provides from 15 to 28 mg/day of iron. Although up to 30% of heme iron can be absorbed from a non-vegetarian diet, as little as 2-5% is absorbed from a plant -based diet. Hence, a low iron diet could decrease daily iron absorption by 40-50%. The efficacy of such a diet was evaluated as an alternative to phlebotomy for communities in whom phlebotomy is not acceptable due to social or other reasons. Tandon, et al., have recently shown that a special low-iron vegetarian diet was able to significantly reduce the serum iron and ferritin levels The reduction in the iron was proportionally greater in patients who had higher iron levels before starting the diet.

AMANTADINE AND RELATED DRUGS

Amantadine has been evaluated as an adjunctive therapy (added to IFN) for patients with chronic hepatitis C who have not responded to IFN alone. Amantadine is an antiviral agent that is effective against influenza A virus. With the theory that the drug could have antiviral effects in patients with chronic HCV, amantadine, and its structural twin rimantadine have been studied. Amantadine given orally is well absorbed and has fewer but serious side-effects (neurological, cardiac, psychiatric and gastrointestinal disturbances.)

A few studies have compared the IFN + ribavirin combination with IFN + amantadine or rimantadine. In a recent study, the complete sustained response in the IFN + ribavirin group was found to be 14% as compared with zero in the IFN + amantadine group. However, preliminary results of a better controlled study show that the viral loss was comparable between the IFN + ribavirin group versus the IFN + amantadine group at 12 weeks.

Whether adding amantadine to the IFN + ribavirin combination could help some of the non-responders to combination therapy was evaluated by Brillianti, et al., in a small randomized study. The final response in the group that received IFN + ribavirin, compared with those who received this combination plus amantadine, was significantly lower (10 vs 70%. SVR (Sustained viral response) was not seen in any patient with double therapy, but was seen in 30% of patients on the triple therapy. Larger studies are required before any conclusions can be drawn.

ANTIOXIDANTS

Antioxidants, in particular vitamin E, have been found to reduce oxidative stress-induced injury to the liver in animal experiments.

In patients with viral hepatitis and increased ALT levels, the plasma levels of vitamin E and the vitamin E/lipid ratios are lower than controls. A high dose of vitamin E-RRR alpha tocopherol (400 IU twice a day) was given for 12 weeks to 23 patients refractory to IFN therapy in a prospective randomized double-blind, cross-over trial. In 11 of the 23 patients, ALT levels decreased by 46%. After stopping vitamin E, ALT levels again increased and on retreatment again declined. Because vitamin E is non-toxic, even in high doses, it could safely be used together with IFN with the hope of slowing progression of fibrosis.

NON-STEROIDAL ANTI-INFLAMMATORY DRUGS

Tenoxicam, a NSAID, was recently evaluated in a dose of 20 mg/day in combination with IFN as compared with IFN monotherapy.

A biochemical response at 6 months was observed in 49% and 43%, and HCV RNA loss in 43% and 38%, respectively). At month 12, there was still no significant difference in the reduction in the ALT level or RNA loss (17 vs 18%). Moreover, three patients developed drug-induced gastric ulcers requiring medical therapy. There was therefore no benefit of adding NSAID to IFN.

In another study, a combination of ketoprofen (100 mg 3 per day) and IFN (3 MU 3 times per week) given for 6 months to IFN non-responders did not show any biochemical or virological benefit.

HERBAL PREPARATIONS

For hepatitis B, herbal products such as phyllanthus have shown some benefit. For hepatitis C, there are no authentic publications in the English literature.

The herbal medicine 'Sho-Saiko-to (Xiao-Chai-Hu-Tang)' has been used in China for nearly 3000 years for the treatment of pyretic diseases. The drug consists of seven herbs, including glycyrrhizin, and has been prescribed for all types of liver diseases, including chronic hepatitis C. It has been shown to decrease the ALT level without significantly decreasing the HCV viraemia and it may also inhibit hepatic fibrosis.

Several other herbal combinations, Dai-Sho-to, Saiko-Keishi-to, Oron-Gedolu-to, Sho-seiruy-to and Toki-Sbakuyaku-San, are being evaluated for their usefulness in the treatment of chronic hepatitis C. Another Chinese medicine, Bing Gan Liu (BG), an oral herbal product, has been evaluated and has properties that protect the liver.

Glycyrrhizin, a herbal product, available as SNMC (stronger neo-minophagen C) has also been shown to decrease ALT levels and decrease the chances of development of liver cancer. However, when combined with IFN, this drug does not improve the response rates.

Recently, a serious concern has been raised about the safety of Sho-Saiko-to and other herbal drugs used in conjunction with IFN. Sixty patients who were treated with this drug developed drug-induced interstitial pneumonia, possibly related to the excess GMCSF production induced by Sho-Saiko-to. More data are therefore needed on safety before the use of these herbal preparations can be assessed.

THYMIC PEPTIDES

Thymosin alpha-1, when combined with IFN and given to treatment-naïve or non-responder patients, showed some benefit. Thymosin is well tolerated and has minimal side-effects when combined with IFN. A single dose and a 5-day multiple dose regimen were reported to be well tolerated. However, the exact dosage of the drug and the frequency of administration need to be established.

MISCELLANEOUS

Several other drugs have been evaluated for the treatment of chronic HCV infection. Ofloxacin, an antibiotic, given in a dose of 600 mg/day was evaluated in two pilot studies as an adjuvant to IFN therapy. Both the studies demonstrated the efficacy of the combination therapy in decreasing the ALT levels as well as HCV RNA levels. No randomized clinical trials are available to justify the use of ofloxacin as an adjunctive therapy for HCV.

GMCSF, a potent biological response modifier, was given in a dose of 65-250 mg/m2 three t imes a week for 6 months or combined with IFN but in neither case was there shown any benefit in the response rates for HCV.

CONCLUSION

Except for IFN, none of the available drugs are effective as a monotherapy. The combination of IFN and ribavirin has been found to be effective for treating both treatment-naïve patients and those

(Continued on page 9)

(**ANGRY**?—*Continued from page 1)*
subjects to 58 subjects with HCV patients without cirrhosis, all of the HCV patients showed a "subclinical neurophysiological impairment." So maybe my observations aren't a figment of my imagination. The other study, done in the UK, reported that those with HCV scored worse in "physical and social functioning, energy and fatigue, and other measures," and ruled out any effect of previous IV drug use. Interestingly, the researchers found that patients with mild Hep C were slower in memory tests, but just as accurate as healthy subjects. A test was done in the US on both HCV positive and negative drug users, and those with Hep C scored higher for depression.

So what causes the anger? Is it all physiological? Maybe some of it is related to dealing with a possibly deadly disease. It may be related to the fatigue or depression caused by Hep C.

What is the mechanism that allows the brain to be affected in liver disease? In the case of people with cirrhosis, the liver can no longer convert ammonia, so it collects in the brain. Ammonia is produced by the body when protein is digested. The blood no longer circulates through a diseased liver where it would usually be filtered and detoxified. Toxins can damage the brain and spinal cord. Encephalopathy can be triggered in people with stable liver disease by several things: loss of blood, too much protein, electrolyte imbalances, especially low potassium levels caused by vomiting or diuretics (eat your bananas!), draining of abdominal fluid, anything that causes alkaline blood pH, low oxygen levels in the body, medications such as barbiturates, tranquilizers, surgery, or any illness.

There is a theory that hepatitis C virus may actually invade our central nervous system. Some brain cells normally die and are replenished by circulating monocytes (a type of white blood cell), as many as 30% a year. These monocytes can possibly by infected with Hep C and make their way into the brain, attacking the brain cells and causing neuropsychiatric symptoms. Scary! But this is just a theory. Post-mortem tests are now being done in London on brain tissue. Researchers also suggest that the virus may hide in the brain, where it is safe from attack by antiviral therapy. There seems to be no relationship between the severity of hepatitis and the cerebral symptoms.

All this sounds very discouraging. So what can we do? If we are constantly exploding with rage, we will alienate our family members, friends, co-workers….

First of all, when we are dealing with our friends with Hep C, we can try to be patient. We can show this article to our significant others, and hope they will understand better. People usually are more prone to anger than usual when taking interferon. Information can help arm us. Then we can start to take action.

Watch your diet:

First of all, don't drink alcohol! Watch your proteins, especially if you have cirrhosis. A high protein diet may cause increased levels of ammonia. Try to get your protein from vegetable rather than animal sources. Keep your blood alkalized and blood sugar levels stable by eating a high carbohydrate, low fat and protein diet. Eating bananas and whole grain foods promote relaxation and sleep. Foods with soy protein and eggs lead to alertness.

Eat your biggest meal in the early part of the day to avoid restlessness and insomnia. It's good to keep a journal to see how your eating habits relate to your emotions, moods, and physical health. Avoid preservatives, additives, colours and illegal drugs or legal drugs, or at least use the smallest dose possible. Sugar is a drug which leads to fat storage. Fructose may be a better choice. Eliminate white flour products, fried foods, processed or fast foods, pasteurized and homogenized dairy products, antibiotic and hormone fed animals, addictive substances of all types, and chlorinated or fluoridated water.

Alter your lifestyle:

Smoking by the patient, or even smoke in the atmosphere, will increase measured levels of ammonia. Did you know that one cigarette smoked 1 hour before a blood test will increase the blood ammonia?

Avoid all toxins, antacids, any medication with ammonium, and if possible, sedatives and tranquilizers. Things like chiropractic, acupuncture, yoga, breathing exercises, visualisation, and/or meditation can help ease your stress levels.

Just like your mother said: Get as much exercise, fresh air and sunshine as you can.

Calming audiotapes or CDs can help, and there are some good ones with positive self-talk. It's important to maintain a positive, happy attitude.

Try stress-reducing herbs such as chamomile, thyme, lavender, lemon balm, calendula, marjoram, peppermint, rosemary, and St. John's Wort, (there are warnings about taking St. John's Wort with other antidepressants) in reasonable amounts, and **after consulting with your doctor.**

Channel your anger into something positive, like letter campaigns for more clinical trials, and volunteer work..

Get medical help. At present there is not much the medical profession will do to help with subclinical neuropsychiatric complications of HCV, since many doctors do not recognize them as such. If, however, you are suffering from clinical (more serious) encephalopathy, your doctor can be of immense help. What can a doctor do to treat encephalopathy? Lots! Blood loss can trigger brain fog. The doctor can stop blood loss from gastrointestinal bleeds with endoscopy and cauterization. To get rid of the toxins like ammonia that collect, the physician can prescribe laxatives, such as Lactulose, and enemas. A reduced- or no-protein diet may help, but this is not for everyone. Tube feedings may be necessary, and Neomycin can reduce ammonia production by intestinal bacteria. If the Hep C is "cured" with interferon or interferon plus ribavirin, this stops the inflammation and fibrosis, and, of course, the brain fog. (It can even clear up early cirrhosis.) Yes, the side effects are uncomfortable, but so is end stage liver disease. Even if you don't get rid of the virus, the interferon can slow the progression of cirrhosis. Brain function seems to normalize with antiviral treatment. In the meantime, the doctor can prescribe antidepressants for those on treatment, where absolutely necessary, since the treatment itself can cause emotional disorders. Successful transplantation will take care of brain fog, but the anti-rejection medications can cause mood swings and anger.

Get counselling.

One last note: Please, if you notice any change in your mental state, or in any of your neurological functions, call your doctor. Hepatic encephalopathy can rapidly become an emergency condition!

References:

HEPATIC ENCEPHALOPATHY http://members.aol.com/HCVWD/he.html

HCV and Brain Dysfunction, by Jules Levin http://thelab.upmc.edu/UTSO/A/ammonia.htm

Hepatic Encephalopathy http://accessatlanta.adam.com/ency/article/000302trt.htm

Healing Sounds http://thelab.upmc.edu/UTSO/A/ammonia.htm

Healing the Liver (Anger) http://www.theflow.org/qigong/liver.htm; http://www.ncbi.nlm.nih.gov/

From Martial Arts of China presents Chi Kung Issue 1, 1991, Page 17 Courtesy of Shaolin Brand http://infinite.org/library/pages/SBMACCK-17.html

PROMOTING HEALTH AND VITALITY THROUGH FOOD http://community-2.webtv.net/essentialhealth/EMOTIONALHEALTH/

Your Body's Wisdom, by Teshna Beaulieu, DC http://www.newvis.net/f99-9.htm

WARNINGS

BEWARE OF THYMUS PRODUCTS

Source: Reuters Health, Jul 26, 2000. "'Herbal' supplements can contain animal parts" by Amy Norton

Although there is no evidence of any herbal product being contaminated, experts are considering the possibility that herbal supplements, such as thymus products which some Hep C patients take, may contain "raw animal parts." Theoretically, the risk of transmitting "mad cow" disease could exist. Dr. Scott A. Norton, in an interview with Reuters Health, stated, "I would advise all of my patients **not to take supplements that contain central nervous system tissue from animals**."

The article warned readers that not all supplements list their full ingredients, or some people may not realize that the word "hypothalamus" means brain tissue, and "orchis" means bull testicles. It says that regulatory institutions have little or no power over dietary and herbal supplements.

ALENDRONATE

Source: NEJM 2000,343: 5, Halabe, Aaron M.D., et al., "Liver Damage Due to Alendronate:

Alendronate is used to treat people with osteoporosis. A 71-year-old woman with a possible history of primary biliary cirrhosis and normal liver function, was treated with Alendronate. Two months later, routine blood work showed high liver enzymes, which returned to normal slowly after stopping the Alendronate. The patient was negative for hepatitis A, B, C and other viruses. Biopsy showed liver damage, but no primary biliary cirrhosis.

Another case of hepatitis as a result of alendronate treatment was recently reported in a 77-year-old woman.

Physicians treating patients with a bisphosphonate should **check for liver damage**.

SPORTS TRANSMISSION?

Source: Reuters Health Aug 09, 2000 Hepatitis C transmitted during bloody fight

Researchers in France seem to have documented the first transmission of HCV to occur during a fight. This discovery should put those involved in **high-impact sports, such as boxing, football, and rugby**, on guard.

A man tested positive for HCV, but had no usual risk factors. He then reported a fight with his nephew that took place 2 months earlier, in which both men bled, and then shared a handkerchief to clean up their blood. Upon performing PCRs on both men, the results showed they had "nearly identical strains of the virus." There had been no sharing of razors or toothbrushes, and the men did not live together.

The authors of the article suggest that **single-use or disposable material be used to clean up blood** during sports or fights.

RESEARCH

RESEARCH NEW GENERATION OF HCV THERAPIES

Source: Wall Street Journal (www.wsj.com) (07/18/00) P. B7; Hensley, Scott "Researchers Find Two Genes Used by Hepatitis C"

Researchers at Immusol Inc. and the University of California at San Diego (UCSD), found two human genes that the hepatitis C virus (HCV) uses to reproduce itself. The discovery of the genes may help find better drugs to fight HCV. The newly discovered genes are necessary for HCV reproduction, **so drugs to block these genes might stop hepatitis C infections better than the current interferon/ribavirin therapy**. Right now, the experiments have been done in test tubes, and not in animals or humans. Further research will be necessary.

TIMELINE FOR CIRRHOSIS TO LIVER CANCER AND DEATH

Source: Gut 2000;47:131-136 "Hepatitis C virus related cirrhosis: time to occurrence of hepatocellular carcinoma and death," F Degosa, et al.

From January 1987 to January 1997, 416 patients with HCV related Child-Pugh stage A cirrhosis were studied in Paris from diagnosis of cirrhosis until death or until June 1, 1998, to see how many developed cancer and how many died. Of the 416 patients, 60 developed HCC (liver cancer) with a five year rate of 13.4% and 83 died (including 34 with HCC), with a five year death rate of 15.3% (95% CI 12.6-18.0%). The results were dependent on age, gender, presence of oesophageal varices, low platelets, bilirubin level, and tobacco consumption. The researchers concluded that the **rates of liver cancer and mortality are much higher than previously reported.**

TMCA DECREASES LIVER FIBROSIS AND CHOLESTASIS IN RATS

Source: J Appl Toxicol 1997 May;17(3):145-151, Trimethylcolchicinic acid decreases liver fibrosis and cholestasis induced by prolonged biliary obstruction in the rat, Muriel P, et al., Centro de Investigacion y de Estudios Avanzados del IPN,Departmento de Farmacologia y Toxicologia, Mexico, D.F., Mexico.

Although it is known that Colchicine is effective in decreasing hepatic fibrosis, toxic reactions have been reported, which are thought to be because it binds tubulin. Since trimethylcolchicinic acid does not bind tubulin, researchers in Mexico tested its ability to decrease liver fibrosis and cholestasis in rats. Trimethylcolchicinic acid (TMCA) was given to the rats 4 weeks after biliary obstruction was induced, and treatment continued for 4 weeks. The liver was analysed and showed that TMCA was able to improve normal liver histology, ultrastructure, collagen content and liver damage.

UCD VACCINE INCLUDES MUTATIONS

Source: http://www.newsrx.com/main/, Newsrx.com, Hepatitis C Vaccine Represents Major Mutations in Isolates

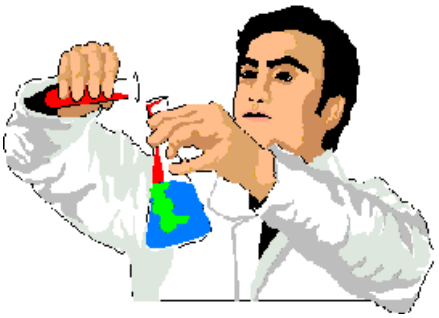
The problem in developing a vaccine for hepatitis C is the fact that the virus mutates so easily. Researchers at University of California at Davis **designed a synthetic vaccine for the virus incorporating the most common mutations** that are found in the regions HVR 1 and HVR2 of the virus. This vaccine takes into consideration all 800 of the mutations found so far. Blood samples from HCV+ donors were tested to see if they reacted to the vaccine, and 80% did so.

COPPER MAY HURT LIVER

Source: Journal of Gastroenterology and Hepatology 15 (7), 786-791, "Fatty Liver, Chronic Hepatitis C and Hepatocellular Carcinoma: Accumulation of copper in the liver and hepatic injury in chronic hepatitis C," Ryoji Hatano, et al.

In order to understand the connections between fibrosis and the presence of copper, iron and zinc in the liver, researchers decided to measure these minerals in the livers and blood of Hep C patients. The study was done on 41 patients with different stages of fibrosis. The presence of the minerals was measured by biopsy by particle-induced X-ray emission, and in blood by flameless atomic absorption spectrometry.

Copper in the liver increased in relation to the amount of fibrosis and bilirubin, and with type IV collagen. Iron and zinc in the liver was not significantly different in the various stages of fibrosis. The researchers believe that **copper may damage the liver.**



TREATMENT

TAILOR-MADE THERAPY

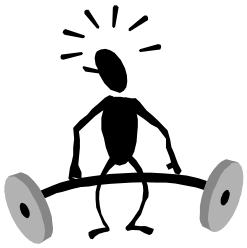
Source: http://www.wellweb.com/INDEX/qhepit2.htm, Hepatitis C Therapy Should Be Individually Tailored, May 5, 2000

F. Blaine Hollinger, M.D, says that **therapy should be given according to genotype and viral load**, that many patients will respond if given enough interferon. Based on his studies, the best induction period for **genotype 1 patients is believed to be 15 mcg daily for 10.4 weeks**, to bring virus down to undetectable levels. Patients with **low viral loads, or who are not genotype 1, have best results taking 9 mcg of IFN alfacon-1 daily for 4 weeks** and then 9 mcg three times a week for 44 weeks. Patients with **high viral loads or genotype 1 may respond better with 15 mcg of IFN alfacon-1 daily for 10 weeks**, and then 9 mcg three times a week. "We often will... treat a patient for four weeks with high dose induction therapy, and then look and find out whether they have undetectable virus at that time," he says. "If they do, then I will switch them to every other day therapy. If they don't, I'll continue on for at least 10 weeks of daily therapy and then switch them to every other day after that and continue the therapy for perhaps in that case **up to a year instead of six months**."

LOW-IRON DIET

Source: Br J Nutr 2000 Mar;83(3):235-9, Beneficial influence of an indigenous low-iron diet on serum indicators of iron status in patients with chronic liver disease, Tandon N, et al., New Delhi, India.

In patients with chronic liver disease, it is common to see iron stored in the liver. Phlebotomy, or blood letting, is sometimes used to improve the results of IFN treatment. These researchers looked into the benefits of a low-iron diet in 19 patients, 10 with normal iron levels, and 9 with high (over 25 mumol/l) levels. Their dietary iron was reduced by half, on a rice-based diet. Blood levels were studied at 1 month and at 4 months. Dietary iron and body weight were closely monitored, and all patients followed the diet. At the end of 4 months, iron levels had gone down in both groups, but went down earlier in the second group. **ALT levels also went down in both groups. A low-iron diet may enhance IFN therapy.**



TREATMENT OF PATIENTS WITH NORMAL ALTS

Source: Nutt, Angela K. et al., "Liver biopsy in the evaluation of patients with chronic hepatitis C who have repeatedly normal or near-normal serum alanine aminotransferase levels," Revised 21 March 2000 and The American Journal of Medicine, 109:1:66-67, Kenneth R. Hirsch A and Teresa L. Wright, " The dilemma of disease progression in hepatitis C patients with normal serum aminotransferase levels."

More and more, hepatitis C is being diagnosed in people with normal blood tests. Neither genotype, viral load, quasispecies variations, nor ALT levels have been associated with actual damage done to the liver. Researchers have found that 20% of patients with normal ALTs had extensive fibrosis or cirrhosis.

The NIH conference in 1997 decided that treatment for those patients with normal ALT levels was not beneficial. However, the second article mentioned above says that ALT levels are not constant, and also recommends that patients be tested for the virus, not just the antibodies before deciding upon treatment. It says that several studies have shown **response rates to IFN to be 20% in patients with normal ALTs**, **similar to those with abnormal ALTs.**

Liver damage is generally worse in those with abnormal ALTs, but 18% of patients with advanced fibrosis or cirrhosis have been found to have normal ALTs.

Both sets of authors agree that "**it may be worthwhile to perform liver biopsies in all patients with hepatitis C**."

NEWS

1000 CASES OF HCV A YEAR IN HEALTHCARE WORKERS

Source: Reuters Health, Aug 08, 2000 "Cost of Treating HCV Infections Among Healthcare Workers Could Double by 2021" By Eliza Bussey

Each year, 1000 new cases of hepatitis C are reported in healthcare workers. Average treatment costs per person range from $50,000 for those who receive early treatment, to over $1 million to those who require a transplant. Costs should almost double by 2021. There is no vaccine, and Hep C is the most common blood-borne virus.

Hospitals should be **using the latest safety devices** to control the spread of Hep C among their workers, and should **review and update their exposure control plan each year**. If a worker is using the same needle device as 5 years ago, the product is probably not the best.

HCV INFECTION LASTING 50 YEARS

Source: http://www.nytimes.com/library/national/science/health/041100hth-hepatitis-infection.html

Edward J. Woodland, Jr., gave some blood samples 50 years ago for a military study of strep throat. Thanks to a zealous scientist, Dr. Edward L. Kaplan, those blood samples were saved from imminent destruction and tested for hepatitis C. Mr. Woodland had no idea he was infected with HCV until he was tracked down recently. This is seen as **proof that the life span of those infected is not necessarily cut short.** Mr. Woodland has no idea of how he was infected, but his blood sample, taken when he was 19, is proof that he was, and his PCR, evidence that he is still infected. Tests showed 3.18 million copies of HCV and elevated liver enzymes. He and his doctor are still contemplating biopsy and treatment. Some doctors believe that it is safest to treat everyone, while other doctors adopt a "wait-and-see" attitude. If treatment were not so difficult and full of side-effects, and doctors knew how fast a patient's disease would progress, there would not be such a dilemma.

Out of samples from 8,568 men in the study, 17 men were found to be infected with HCV--the same percentage as is found today in military recruits. Seven of the men had since died, but only one of them had had chronic liver disease, and he died 42 years after the blood sample was given.

Research has usually investigated patients who have come to their doctors with complaints, so often they are the sickest of those infected. These patients are an example of how deadly Hep C can be. Until there is universal testing, it will be difficult to have a clear picture of the progression

(Continued on page 9)

*(**News**—Continued from page 8)*

of the disease. Although this may be bad news, in that governments might not take the disease seriously, this study doesn't take into account the mutations of the virus that have since taken place. In the meantime, this should reassure some of us that we may live longer than we thought.

LIVERS GO TO SICKEST

MedscapeWire August 9, 2000 Urgent Liver Patients Receive Higher Proportion of Transplants

Of all the people in the US waiting for a liver transplant, **those within days of dying**, those classified as Status 1 and 2A, presently **receive about 1/3 of available livers**, whereas before 1997, those patients were not so lucky. Status 1 and 2A patients make up about half or a percent of those on the waiting list. Some doctors question this distribution, asking whether or not livers are being given to those who will make the best use of them.

The present mandate of UNOS is to distribute livers to the sickest patients within a given area before sharing them with people less sick outside the area. This may seem logical, but on the other hand, patients are being transplanted when they are sicker, and they tend to have more complications and less chance of survival. UNOS will review its policy in November. The best situation would be that there could be enough livers for everyone.

*(**Management**—Continued from page 5)*

who relapse after an initial course of IFN monotherapy. However, because a large proportion of patients still do not respond to this therapy or are unsuitable for the protocols, there is an urgent need to search for new drugs and adjunctive therapies.

UDCA and conventional NSAID have not proven to be of any benefit. Use of iron reduction therapy, including a low iron diet and lactoferrin, need further evaluation. Although the available herbal products have some properties that protect the liver, but none kill HCV, they offer little advantage in the short term. However, their long-term effects on liver fibrosis and clinical outcomes should be studied. The use of antioxidants such as vitamin E is attractive, not only because the drug is non-toxic, but also because it has the potential of reducing the oxidative stress-induced injury and ongoing liver fibrosis produced by chronic hepatitis C.

Patients who are non-responders to IFN and ribavirin have few options available. The use of amantadine or rimantadine or thymic peptides in higher or more frequent dosages needs further evaluation in large trials. Finally, it is imperative to keep in mind the cost effectiveness and the quality of life improvement before recommending any new therapy for hepatitis C.

NEWS FROM THE OTTAWA-CARLETON GROUP

by Ron Lee

The Ottawa Hospital has opened a Hep C clinic with multi-medical specialities on call, including a social worker, guidance counsellor, therapist, etc. They are being very co-operative with us and consulting at every turn.

We have a very active "Joint Council" on Hep C functioning, which encompasses all the organisations and groups with an interest in Hep C in Ottawa. A partial list includes: Canadian Liver Foundation, City Health Department, haemophiliacs, native groups, HIV/AIDS, Ottawa Hospital Clinic. There are 12 organisations attending our monthly meetings. We have had four meetings so far, and everything is going great. We spearheaded the effort, and chair it, and are amazed at the response and cooperation. The main purpose of the "Counsel" is to coordinate all our collective efforts, to make sure we do not duplicate services, and make sure we don't tread on others' turf. It could be a model for other cities. We are starting to get money now from the Federal Government, and all want to make sure the money is wisely spent.

Our next meetings are September 13, October 11, and November 14, all at 420 Cooper Street.

HEPCBC COMMUNITY LIBRARY NOW OPEN

Thanks to the generosity of Elsevier Science, the Massachussets Medical Association, Blackwell Science and the San Francisco Hep C Support project, HepCBC now has full access to the following journals.:

- *American Journal of Gastroenterology*
- *The Lancet*
- *Journal of the American Medical Association*
- *Hepatology*
- *New England Journal of Medicine*
- *Journal of Gastroenterolgy and Hepatology*

Community members are welcome to search these journals online at the computer terminals at our library for the latest information on HCV and HCV/HIV co-infection. Thanks as well are due to the Victoria Persons with AIDS Society where the library is housed. ***The library is located at 541 Herald Street in Victoria. For hours of operation call : (250) 382-7927.***

COMPENSATION

BRITISH COLUMBIA

1986-1990
Bruce Lemer/Grant Kovacs Norell
Vancouver, BC
Phone: (604) 609-6699 Fax: (604) 609-6688

Before August 1, 1986 or 1990-1991
David A Klein/ Klein Lyons
Legal Assistants: Lisa Porteous and & Candace Wall
Vancouver, BC (604) 874-7171, 1-(800) 468-4466, Fax (604) 874-7180

also:

William Dermody/Dempster, Dermody, Riley and Buntain
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
Toronto, Ontario
Phone: (416) 595-2300, Fax: (416) 595-0527

TRACEBACK PROCEDURES:

INQUIRIES-CONTACT:

The Canadian Blood Services
Vancouver, BC
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.

RCMP Task Force TIPS Hotline
(Toll free) 1-(888) 530-1111 or 1 (905) 953-7388
Mon-Fri 7 AM-10 PM EST

CLASS ACTION/COMPENSATION

If you would like more information about class action/compensation, or help with a lookback, contact:
Leslie Gibbenhuck Tel. (250) 490-9054
E-mail: bchepc@telus.net
She needs your name, address, birth date, transfusion dates, and traceback number.

National Compensation Hotline: 1-(888) 726- 2656

ADMINISTRATOR

To receive a compensation claims form package, please call the Administrator at 1(888) 726-2656 or 1 (877) 434-0944.
www.hepc8690.com info@hepc8690.com

***Should you have any questions about the status of your claim (86-90), please contact the administrator. They should answer all of your questions. If, however, they do not, then please contact Bruce Lemer who has promised me that he would answer your questions at no charge.—C.D. Mazoff*

COMING UP IN BC:

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

Chilliwack BC HepTalk Meetings: 2nd and 4th Wednesdays of each month, 7-9 PM, Chilliwack United Church 45835 Spadina. NEXT MEETINGS: Sept 13th and 27th. Contact: HepTalk@fraservalleydir.every1.net, or 795 4320

Comox Valley Liver Disease Support Group Meetings: Third Tuesday of each month, 6-8 PM, St. George's United Church on Fitzgerald. NEXT MEETING: Sept 19th. Drop in daily for coffee. Contact: Ingrid or Nicky, 335-9167, nickyrussell@sprint.ca

Cowichan Valley Hepatitis C Support Contact: Debbie, 715-1307, or Leah, 748-3432.

Cranbrook HeCSC : Meetings: 1st and 3rd Tuesday of each month, 2-4 PM, #39 13th Ave South, Lower Level. NEXT MEETINGS: Sept 5th and 19th. Contact: 426-5277, hepc@cyberling.bc.ca

Creston Educational presentation and appointments: Contact Katerina 426-5277

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: Sept 24th. Contact: Marjorie, 558-7488, amberose@sunwave.net

Golden Client Support Services & Healthcare Professional and Service Providers Educational presentation and appointments: Golden Health Unit. Contact Katerina 426-5277

HepCBC Hepatitis C Education and Prevention INFO Line. Need free medical articles or other info? Contact: David, (250) 361-4808, info@hepcbc.org, www.hepcbc.org

Invermere Educational presentation and appointments: Invermere Hospital. Contact Katerina 426-5277

Kelowna HeCSC Meetings: First Saturday of each month, 2-4 PM, Rose Avenue Education Room, Kelowna General Hospital. NEXT MEETING: Sept 2nd. Contact: Doreen, 769-6809 or eriseley@bcinternet.com

Kootenay Boundary Meetings: Second and fourth Tuesday of each month, 7 PM, 1159 Pine Ave, Trail. NEXT MEETING: Sept 12th. Contact: Brian, 368-1141, k-9@direct.ca. Meeting for September 2nd Tuesday of the month only

Mid Island Hepatitis C Society Meetings: Second Thursday of each month, 7 PM, Health Unit-Central Vancouver Island, 1665 Grant St., Nanaimo. NEXT MEETING: Sept 14th. Contact: Susan, 245-7654, mihepc@home.com, or Rose, 714-1937.

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

Nelson Hepatitis C Support Group Meetings: 2nd Floor 333 Victoria St., Multi-Purpose Room NEXT MEETING: Contact: Alex at ANKORS 1-800-421-2437 or 505-5506, or Ken 355-2732, keen@netidea.com

New Westminster Support Group Meetings: Second Monday of each month, 7:00-8:30 PM, First Nations' Urban Community Society, Suite 301-668 Carnarvon Street, New Westminster. NEXT MEETING: Sept 11th. Contact: Dianne Morrissettie, 525-3790.

Parksville/Qualicum 102a-156 Morison Avenue, PO Box 157, Parksville, BC V9P 2G4. Open daily from 9AM to 4 PM, M-F. Contact: 248-5551, sasg@island.net

Penticton Hep C Family Support Group Meetings: Second Wednesday of each month, 7-9 PM, Penticton Health Unit, Board rooms. NEXT MEETING: Sept 13th. Contact: Leslie, 490-9054, bchepc@telus.net

Powell River HepC Information and Support: Contact: Cheryl Morgan, 483-3804.

Prince George Hep C Support Group Meetings: Second Tuesday of each month, 7-9 PM, Health Unit Auditorium. Next Meeting: Sept 12th. Contact: Gina, 963-9756, 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: Sept 9th. Contact: Brad, 295-6510, citizenk@nethop.net

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

Smithers Contact: Doreen, 847-2132 or aws@mail.bulkley.net

Sunshine Coast — Sechelt: First Wednesday of each month. NEXT MEETING: Sept 6th—**Gibsons**: Last Thursday of each month. NEXT MEETING: Sept 28th. Both meetings—Health Units, 7 PM. Contact: Kathy, 886-3211, kathy_rietze@uniserve.com

Vancouver CLF Meetings: Second Thursday of each month, 7:30 PM, Nurses Residence, VGH (12th & Heather). Next Meeting: Sept. 14th. Contact: CLF, 681-4588, or Herb, 241-7766, HMoeller@compuserve.com

Vancouver Morning Support Group Meetings: Last Wednesday of each month, 10:30-12:30, BC CDC Building, 655 West 12th (Park in Cambie St. City Square Mall). NEXT MEETING: Sept 27th. Dr. Farley from the Viridae Clinic will be the guest speaker. Contact: Darlene, 608-3544, djnicol@attglobal.net, or info@hepcvsg.org.

Vernon HepCURE Contact: Marjorie, 546-2953 for Hep C information. amberose@sunwave.net

Vernon HeCSC HEPLIFE Meetings: Second and fourth Wednesday of each month, 10 AM-1 PM, The People Place, 3402-27th Ave. NEXT MEETINGS: Sept 13th and 27th. Contact: Sharon, 542-3092, sggrant@netcom.ca

Victoria HeCSC Contact: 388-4311, hepcvic@idmail.com

Victoria HepCBC Support Groups We have small support groups for men and for women. For men, contact Guy at 382-9888, kidsturn@home.com; for women, contact Joan at 595-3882, or jking@hepcbc.org

OTHER PROVINCES

ALBERTA:

Central Alberta CLF Hepatitis C Support Group Meetings: Last Thursday of each month, 6-8 PM, Provincial Building, Room 109, 4920 51 St., Red Deer. Enter at southeast entrance. NEXT MEETING: Sept 28th. Contact: Shane, 309-5483, shanehepc@hotmail.com

Edmonton, AB Hepatitis C Informal Support Group Meetings: Third Thursday of each month, 6-8 PM, 10230-111 Avenue, Edmonton, Conference Room "A" (basement) NEXT MEETING: Sept 21st. Contact: Cathy Gommerud, yzcat@telusplanet.net or Jackie Neufeld, 939-3379

ATLANTIC PROVINCES:

Cape Breton Hepatitis C Society Meetings: Second Tuesday of each month. NEXT MEETING: Sept 12th. Contact: 564-4258 (Collect calls accepted from institutions) Call toll free in Nova Scotia 1 (877) 727-6622

Fredericton, NB HeCSC Meetings: 7 PM Odell Park Lodge. NEXT MEETING: Contact: Sandi, 452-1982 sandik@learnstream.com

Greater Moncton, N.B. HeCSC Meetings: First Thursday of each month, 7 PM. Place to be changed. NEXT METING: Sept 7th. Contact Debi, 1 (888) 461-4372 or 858-8519, monchepc@nbnet.nb.ca

Halifax Atlantic Hep C Coalition Meetings: Third Saturday of each month, 1-3 PM, Dickson Centre, VG Hospital, Rm 5110. NEXT MEETING: Sept 16th. Contact: 420-1767 or 1-800-521-0572 or ahcc@ns.sympatico.ca

Kentville Atlantic Hep C Coalition Meetings: Second Tuesday of each month, 6:30-8 PM, Kingstec Campus, Rm 214. NEXT MEETING: Sept 12th. Contact: 1-800-521-0572 or ahcc@ns.sympatico.ca

ONTARIO:

Durham Hepatitis C Support Group Meetings: Second Thursday of each month, 7-9 PM, St. Mark's United Church, 201 Centre St. South, Whitby, ON. NEXT MEETING: Sept 14th. Contact: Smilin' Sandi, smking@home.com http://members.home.net/smking/ or Durham Region Health Department (905) 723-8521 or 1-800-841-2729 Ext. 2170 (Ken Ng)

Kitchener Area Chapter Meetings: Third Wednesday of each month, 7:30 PM, Cape Breton Club, 124 Sydney St. S., Kitchener. NEXT MEETING: Sept 20th. Contact: Carolyn, 893-9136 lollipop@golden.net

Hep C Niagara Falls Support Group Meetings: Last Thursday of each month, 7-9 PM, Niagara Regional Municipal Environmental Bldg., 2201 St. David's Road, Thurold, ON. NEXT MEETING: Sept 28th. Contact: Rhonda, 295- 4260 or hepcnf@becon.org

Hepatitis C Society of Ottawa-Carleton Meetings: Centertown Comm. Health Centre, 420 Cooper St. (Ottawa) between Bank and Kent St. One on one peer counselling Mon. afternoons. NEXT MEETING: Sept 13. Contact 233-9703 or ronlee@attcanada.ca

QUEBEC:

Hepatitis C Foundation of Quebec Meetings: Dawson Community Centre, 666 Woodland Ave., Verdun. NEXT MEETING: Contact Eileen: 769-9040 or fhcq@qc.aibn.com