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Canada's Hepatitis C News Bulletin

www.hepcbc.org

DDW WRAP-UP

By Alan Franciscus, Editor, HCV Advocate and Patty Perkins, MS, MPH

Digestive Diseases Weekly (DDW) Conference is the second largest annual meeting on the GI track held in the country. A good portion of this meeting is dedicated to liver disease but does not have the intense focus of liver disease, as does the annual conference held by the American Association for the Study on Liver Disease (AASLD). This year's DDW conference was held from May 19-23, 2001 in Atlanta, GA.

Much of the information presented on HCV dealt with future HCV treatments, and primarily with pegylated interferon monotherapy and in combination with ribavirin. The focus of this article is to acquaint the reader with brief snippets of information, besides treatment options, presented at this year's conference. We will be featuring more in-depth articles in future issues of the *HCV Advocate*.

HCV Pathogenesis

One session focused on studies that are trying to determine how the body naturally eliminates HCV. We know that between 20-30% of people who become infected with HCV clear the virus spontaneously on their own. A couple of recent studies have examined and tried to discover how this process occurs, and have come up with genetic mutations that predicted the inability of the body to naturally eliminate HCV. This is a good first step and will hopefully lead to the mechanism that allows natural HCV elimination. This research has excellent potential for development of new drugs to treat HCV.

Liver Transplantation

Another session discussed changes needed in the current organ allocation system. The new Model for End Stage Liver Disease, or "MELD," is an attempt to rectify current inconsistencies, such as long waiting lists and the irregularities in regional organ allocation. While the MELD system will much improve the current system and eliminate some bias, there are some flaws that need to be addressed. The MELD is open for public comment until August 2001.

Compliance and Response in African Americans in a Prison Population

We already know that African Americans do not respond so well to treatment with current HCV medications as do Caucasians. We know that part of this non-responsiveness is due the fact that the majority of HCV+ African Americans have genotype 1, the most difficult genotype to treat. A study conducted in prison of 60 prisoners treated with standard interferon and ribavirin shows two things: one, that prisoners can be successfully treated and two, that African Americans have similar success rates to others being treated in a prison setting. The authors concluded that treatment within an inmate population is both feasible and has similar (and some-

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DAVID LANG

by Sarah Amber

David M Lang of SeaTac, Washington, died peacefully from complications of hepatitis C on Tuesday, June 26, 2001 at the age of 51.

David Lang was an extraordinary man whose generosity was legendary in the hepatitis and substance-abuse recovery communities. Each person who had the great fortune to meet him came away from an encounter with David spiritually enriched and emotionally refreshed. He was truly one of the great ones. He spoke often at recovery centers in the Seattle area after his liver transplant in February 1996, and because he'd "been there done that," he was able to touch the lives of the clients there in a way that few others could. He was the "voice of reason" on an international email
support list for hepatitis C patients, as well as being a phone support person, and always clearly and articulately explained things. One of David's greatest strengths was that he went straight to the heart of matters and did not skirt the issues at hand. His words and the sincerity behind them made people think, and his influence spanned the globe.

He built computers out of spare parts and gave them to indigent and homebound hepatitis C patients so that they could go on the internet, learn about the disease, and communicate with others, because he knew the immense

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The next issue of the hepc.bull will be a special, combined September/ October issue, which should be out late September. Deadline for submissions is September 5th, please.

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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.

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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.

Peppermint Patti's FAQ Version 4.5 Available NOW!!

Peppermint Patti's FAQ Version 4.5 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.

HepCBC Resource CD: The CD contains back issues of the *hepc.bull* from 1997-2001; the FAQ V4.5; the Advocate's Guide and the Slide Presentations developed by Alan Franciscus. The Resource CD costs $10, including shipping and handling. Please send cheque or money order to the address on the subscription form on this page.

THANKS!!

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CUPID'S CORNER

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

To place an ad: Write it up! Max. 50 words. Deadline is the 15th of each month and the ad will run for two months. We'd like a $10 donation, if you can afford it. Send 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.

Got Hep C?... Single?
...Visit
http://clubs.yahoo.com/clubs/ontariohepcsingles
or
Alberta Hepatitis Singles web
http://clubs.yahoo.com/clubs/albertahepatitissingles

Summer Fruit Salad:

This one is delish, quick and good for you too.

Here are serving suggestions for 2: The list of fruits and nuts are seasonal and optional. Mix and match according to your preferences.

3 large bananas
1 small package of blueberries
2 ripe peaches
2 ripe nectarines
1 handful of raw unsalted cashews
1 handful of raw unsalted pumpkin seeds
1 handful of raw unsalted sunflower seeds
250 ml of 1% Cottage Cheese
A dash of pure maple syrup.

Mix and enjoy.

Some alternatives are: mangoes or cantaloupe instead of peaches; strawberries instead of blueberries; raw pistachios instead of cashews; low fat sour cream for the cottage cheese.

This delish dish is full of antioxidants, vitamins, minerals, carbohydrates, roughage and protein. It is all natural, and very low fat and easy on the digestive system.

THE SQUEEKY W HEEL

We plan and God laughs..

As some of you know, I decided to fly to Seattle for the celebration of Dave Lang's life. It was really important to me to be there.. and to finally meet Alice, his wife, and to see Sara and meet Pam Cobb. But life has a way of doing a few twists instead...I flew out to Seattle Thursday night.

I got to check out the inside of a lovely hospital in the Seattle area on Friday morning (July 6). Seems, for reasons that are not clear, I had an esophageal varice bleed.

It is still hard to believe!!!. Anyway, at 6 AM Seattle time I got out of bed in the Marriott, feeling a little woozy...figured I was hungry. The next clear memory was of being face down on the carpet between the vanity sink and the closet (mirrored door of course) and wondering how cherry pie filling could have gotten all over my arms and body.

When I pulled myself up and looked in the mirror, there were bright red spatters on the mirror and wall. My arms were still coated...how very odd...couldn't go to breakfast like that...next move...take a shower to get the cherry pie off.. held onto the shower hand bar...decided that stretching out in the tub would be easier...when I came to again I said...damnit!! I'm not letting anyone find me naked and covered with blood in a bath. Somehow I pulled myself up… My next vision was of the underside of the toilet bowl.

Vanity is everything. I wobbled into the bed area, put on my nightgown, got under the covers and THEN called Sarah and Pam.. left a message saying.. I think I am sick .. please come right away!!! and then.. called the hotel emergency.. by the time the EMT arrived .. in a few seconds.. Sara had called.. and arranged for me to be transported to Highline Hospital where Sara's hep doc is located.

What a break. The hospital was WONDERFUL. I opened my eyes to see Sara standing next to the gurney. And then Pam Cobb came in, and I said to her, Ahh. you have the face of an angel!!!!!

THE ER doc was a riot.. and wonderful.... and the hep doc Peter Hartwell, just the best. I was immediately admitted to a hospital room with a view of Mt Rainer out the window. I got scoped, banded and loaded with fluids to replace my drop in liquid and blood pressure.

The doc was going to Dave's celebration which was the ONLY reason he released me on Saturday. My blood count was up to about 27 by then. Pam Cobb picked me up at the hospital, and stayed with me until we left for the celebration. Others babysat me the entire time.

The Marriot had lovingly moved me to a new room (they will be renting the original at double the price and calling it the SHINING Suite), and placed all my belongings exactly where they had been.

Dr. Hartwell gave permission for me to fly home on Sunday with meds to reduce portal pressure. Ron (my partner) fetched me at the airport. He was pretty freaked out.

I called my hepdoc this morning. He said, YOU DID WHAT?" This whole episode apparently is not good news. and was totally unexpected. There were no signs that I had varices at all. Apparently I was pretty close to checking out. The EMT's packed up my little bag, complete with my stuffed fox, little DaBuddha, and my purple shawl. Colour coordination is always essential, you know.

Never did get to check out the business centre of the Marriott.

I am okay.. as in alive and home and resting and eating very lightly. No plane rides until I am stable again. I will see my doc here on Wed. Ron has suggested some Cherry Garcia ice cream, but somehow the cherries just don't sound too appetizing.

At the celebration for Dave.. oh yes.. the real reason I am writing.. there was in fact a cranberry relish.. I took Sara and Pam and Prankster, who had arrived from Portland, over to show them and said, "See.. this is exactly what it looked like…" and they all thanked me for my kindness in sharing.

Just to keep the focus where it belonged, those folks were the only friends aware of my medical dance. (Sara, Pam Cobb, Michael aka Prankster and Dr Hartwell) Alice had other things to focus on and the last thing that I needed was using my energy to answer lots and lots of questions.

….and if you ever doubted for a minute the essential connections from this list (Hepv-l) ... I am living testimony to its importance.

We are all angels with one wing.

We can only fly when we embrace each other.

Sybil.

TREATMENT OF HCV IN INJECTION DRUG USERS

Chronic hepatitis C is the most common infectious disease among injection drug users (IDUs). Because of the allegedly poor compliance of IDUs with treatment requirements and conditions, hepatologists recommend treatment only if former IDUs have spent 6 to 12 months drug free. The aim of this prospective study was to investigate whether opiate-dependent IDUs with chronic hepatitis C virus (HCV) infection can be treated successfully with interferon.

Eligibility for the study meant IDUs had to be HCV-RNA positive by polymerase chain reaction. Subsequently 50 inpatients were enrolled during detoxification treatment.

HCV treatment was started with interferon alfa-2a (through 1998) or a combined regimen consisting of interferon alfa-2a and ribavirin (begun in 1998). All patients were treated and supervised by specialized physicians in both hepatology and addiction medicine.

The end point for this study was defined as a loss of detectable serum HCV RNA at week 24 after treatment. The rate of sustained virologic response was 36%. Sustained response rates were not significantly different for patients who relapsed and returned to treatment (53%), relapsed and did not return to treatment (24%), or did not relapse (40%; $P > .05$).

During the 24 weeks after treatment, we were unable to detect any reinfection, even among patients who injected heroin during this period. This surprising result should be examined in further studies.

In conclusion, HCV-infected drug addicts with chronic HCV infection can be treated successfully with interferon alfa-2a and ribavirin if they are closely supervised by physicians specialized in both hepatology and addiction medicine.

Source: HEPATOLOGY 2001;34:188-193

JOURNAL SCAN

by C.D. Mazoff, PhD

This month's flavour, by and large, is cancer. A friend of ours is undergoing treatment for HCC caused by HCV, and we are really trying to help him and others find a way through this ordeal.

There are several pertinent articles from the *Journal of Gastroenterology and Hepatology* on this month's theme:

First is an editorial in JGH (2001) 16 (4), 361-62, which discusses the problems with **chemotherapy**. Chemo does not have a good history on people with HCC; this is because the poorly functioning liver is overwhelmed by toxins and cannot fight back. The side effects are "sometimes very serious," and this can lead to liver failure.

One way around the problem of side effects is to localize delivery of the chemo rather than deliver it systemically. The use of a transcatheter hepatic arterial infusion with an implantable injection port under the skin is one way of getting "effective amounts of agents to the lesion without any serious side-effects." Although the dose is low, those with poor liver function should not be candidates for this kind of therapy.

Another treatment consists of the "oral administration of enteric-coated **tegafur/uracil**." In studies with advanced HCC, survival times were prolonged. As well, renal function was preserved, and there were no adverse side effects ("Improved Survival…" p.458).

More Recently, (*JGH,*2001,16:7), two more editorials caught my eye. The first, "Optimal Surveillance of HCC in patients with patients with chronic viral hepatitis," notes that "symptomatic HCC is a dismal disease with a 1-year survival rate usually less than 20%" (p.715). The trick, then, is to catch HCC at the early stage before it becomes symptomatic. According to the authors, the "ideal modality of surveillance should be non-invasive, highly sensitive, acceptable by patients, and not expensive." After a review of 2 modalities—**alpha fetoprotein blood tests (AFP), and hepatic ultrasonography**, the authors concluded that while some physicians rely on one or the other of these, **BOTH should be used.** AFP is easy to perform, and should be administered **every 6 months** to persons with chronic viral hepatitis who are non-cirrhotic. However, false positives are common, should you be having a flare-up when you are having the test done. To ensure the diagnosis, an ultrasound should be taken. The problem here is that, if the tumour is too small or is near the diaphragm, an ultrasound may not detect it

Another article, "Toward Prevention of HCC developing in CHC," notes that "markers of ongoing HCV are detected in approximately 80% and those of HBV in approximately 20% in HCC patients in Japan" (711-712). In my opinion, these figures are staggering, and I wonder why so much weight is put on HBV in the recent Provincial Hepatitis Strategy for BC. According to the BCCDC, there are approximately 40 000 each of individuals in BC infected with HCV and HBV. Since 85% of those with HCV will progress to chronicity (compared to 15% for those with HBV), and since more people with HCV will develop complications (sheer numbers and proclivity to carcinogenesis), the decision to allocate more resources to HBV does not make sense to me.

The authors of this article state that "accumulating lines of evidence indicate that **HCC occurs rarely, if ever, in the patients who have cleared HCV** from their sera" (p.713). Surely, in this light, a wise approach would be for the governments in Canada to invest in more research for a cure for hepatitis C, as well as to provide treatment to the 26,000 untreated carriers of HCV in this province (BC) alone!

The authors note the problems with current therapies: they clear the virus in less than 50% of patients (I would say a lot less than that), and recommend discussing the use of herbal medicine for the prevention of HCC.

In clinical trials in Japan, patients have been treated with an extract of **licorice**, "glycyrrhizin," in a commercially available form: Stronger Neo-Minophagen C (SNMC), from Nomphagen Pharmaceutical Co, Tokyo, Japan.

The studies showed that "patients who received SNMC ran a **2.5-fold lower risk of developing HCC** than those who did not receive SNMC" (p.713). The main problem with SNMC is that if it is administered orally, the compound is broken down before it reaches the target. It is most effective when injected intravenously. As well, oral administration has certain side effects, such as pseudo-aldosteronism (high blood pressure, heart rhythm irregularities, sodium retention), which cease when treatment is stopped. The authors of the study warn against a weekly dose greater than 1200 mg

At present SNMC is available for use in Japan, Holland, China and Germany. The authors conclude by suggesting that having to self-administer an intravenous injection poses a considerable constraint, and they urge development of an intramuscular means of delivery.

Shining some light on the problem: An article in the *American Journal of Gastroenterology* (vol 96 no 5, 2001) discusses the use of BLT to control itching, so I went out and ordered one (even though they aren't kosher), but I think they put too much mayo on the sandwich!!! Anyway, while I was scratching, I read further and found out that BLT stands for **Bright Light Therapy**, not bacon, lettuce and tomato. No kidding! Apparently using BLT seems to work, because the body tends to itch more at certain times of the day. BLT consists of administering bright lights (10,000 lux) directed at the retina, for up to 60 minutes twice a day. However, the side effects are another matter all together: hypomania, headaches, hallucinations and suicide. My advice: go for a walk instead. Oh yeah, and do it in the daytime, when the sun is shining.

Last: there is a report in this month's *AJG* of the efficacy of **Bezafibrate** in the treatment of hepatitis C. Bezafibrate is currently in use for people with primary biliary cirrhosis. The researchers found that it also **inhibits inflammatory response**. When used on non-responders to standard treatment for HCV, bezafibrate was shown to reduce AST and ALT levels without causing any noteworthy side effects. As well, hepatic impairment was also reduced.

This just in!! Evidence for a cerebral affect of the hepatitis C virus

A team from London, England, investigated whether hepatitis C virus (HCV) affects cerebral function. Patients with HCV infection frequently complain of symptoms akin to the chronic fatigue syndrome. They also score worse on health-related quality of life indices than matched controls.

The researchers used proton magnetic-resonance spectroscopy (1H MRS) to measure cerebral choline/creatine ratios in subjects.

This was performed in 30 patients with histologically-defined mild chronic HCV infection, 29 age-matched and sex-matched healthy controls, and in 12 patients with chronic hepatitis B. They found that the choline/creatine ratios were significantly higher in the white matter and basal ganglia of the HCV group, compared with both the hepatitis B group and healthy volunteers. This elevation was found to be unrelated to hepatic encephalopathy or a history of intravenous drug abuse.

Daniel M Forton, of Imperial College School of Medicine, St Mary's Hospital, London, concluded on behalf of the group, "The elevation in choline/creatine ratios suggests that a biological process underlies the extrahepatic symptoms in chronic HCV infection.

"These findings have implications for the direction of future research and ultimately for patient treatment."

Lancet 2001; 358: 38-9, 10 July 2001
Source www.gastrohep.com

WHO KNOWS?

by Joan King

Let's get a little paranoid for a moment.

Bob has Hep C. He has just applied for a new job. What happens if his prospective employer asks Bob's doctor about his health? Will his doctor tell about the Hep C? Will Bob be refused employment? Will his prospective employers also see that he is being treated for depression, or that he has been treated for an STD?

Maria is buying a house. She has Hep C. She is applying for life insurance. Is the company given her whole medical record?

Leonard, a doctor's receptionist, sees that a Hep C patient, a child, lives in the same neighborhood as one of his friends who has children. What stops him from telling that friend?

Sylvia communicates with her specialist by email. How does she know it won't be intercepted?

Tommy, age 15, has contracted Hep C from sharing needles. Must his parents be told?

How about you? When you present your medical card, what information are you giving out? What's on there, anyway?

Does your doctor keep records in a locked cabinet, where no one can see them? Does the nurse see them? Does the secretary see them? Do they tell government agencies that you are infected with a transmissible disease? Do they tell your insurance company that you have hepatitis C? Who sees the information collected on large databases?

Your prescription for interferon, together with all your other prescriptions, goes on a database. Who sees this information? What has happened to privacy and confidentiality?

And what can happen to us if health information gets out to people it shouldn't? It can lead to employment or social discrimination, financial problems, invasion of privacy, or even "just" plain embarrassment.

In the US, the *Health Insurance Portability and Accountability Act of 1996* recognized the need for national patient record privacy standards. Regulations to guarantee patients new rights and protections against the misuse or disclosure of their health records were released in October of 1999. All medical records and other individually identifiable health information in any form, whether communicated electronically, on paper, or orally, are covered. Both medical personnel and health plans must give patients a clear written explanation of how their health information can be used, stored, and disclosed. A history of most disclosures must be made available to patients. Patient consent must be obtained before sharing information for treatment, payment, and health care operations purposes, or before releasing information to financial institutions for mortgages or loans or life insurers. A doctor cannot refuse to treat a patient if he/she refuses to grant consent to share information for non-routine use. A doctor must provide the minimum amount of information necessary, except in the case where the information is going to another doctor, for treatment purposes.

What can be done?

Written privacy procedures should be adopted that say exactly who is allowed to receive confidential information. Employees must be trained, and a privacy officer should be designated. Complaints processes should be established. In the US, penalties for violations have been put into place, including not only civil penalties, but also federal criminal penalties. There must, of course, be exceptions for cases of emergency, legal cases, national defense and security, law enforcement, public health, etc.

There is no doubt that computerization of medical data can reduce costs and improve care, and remote consultation will be an extremely valuable tool, but at the same time, it creates a confidentiality issue. Computers with confidential information should be protected by passwords. In the case of transmission of sensitive materials via email, some organizations are starting to use firewalls and products to encrypt messages.

Databases can be improved by using patient numbers and separating the medical information from personal information, preferably non-computerized.

In Canada, most provinces have laws to protect confidentiality in the public sector, and the CMA Code of Ethics has attempted to deal with the issue of confidentiality and the patient's right to access records, saying, basically, that the patient has a right to confidentiality unless it would conflict with carrying out the law or would result in harm to others or the patient, or if the patient is incompetent. Doctors must get authorization from their patients before releasing information, and should let the patient know what information will be disclosed. The CSA (Canadian Standards Association) has developed a Model Code for the Protection of Personal Information. Most public health associations have set up systems of independent auditing.

There is no one solution, but there are several strategies which, combined, can do much to protect the patient and ensure the best care possible.

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BONE MASS AND VIRAL HEPATITIS

By Will Lawson

The liver plays a central role in bone metabolism. Several studies show that cholestatic liver diseases, liver transplantation, hepatitis C, and interferon combination therapy can each result in decreased bone mass or impaired mineralization of the bone protein matrix.

For example, in a Spanish study, bone mineral density and biochemical bone markers were studied in 32 male patients (aged 31-48). They had been treated for 12 months with either interferon (group 1) or interferon plus ribavirin (group 2). No patient showed prior obvious evidence of bone disease, was cirrhotic or an abuser of alcohol, or had taken any other medication in the previous 12 months.

The findings were as follows: Bone mineral density was significantly lower in group 2 than in group 1—21 percent of the group 2 patients had readings indicating osteoporosis, and the remaining 79 percent had readings indicating osteopenia. Z-score values were significantly lower in group 2. Urinary calcium excretion and urinary calcium/creatinine ratio were also lower in group 2. No patients had symptoms of bone fractures.

In an Italian study, 25 male patients (aged 41-59) with chronic hepatitis attributed to the C virus were studied. Patient health criteria were similar to those in the Spanish study (but it is unclear from the report whether treatment for liver disease was a factor).

The study found that 64 percent had reduced bone mineral density. No correlation was found with the patients' ages.

There are two overarching conclusions:

- **Treatment of chronic hepatitis C with interferon plus ribavirin might induce bone loss in all treated patients**. One theory is that ribavirin interferes with the intestinal absorption of calcium. New studies are mandatory.
- Physicians should investigate the bone health of patients with chronic liver disease, since they may require therapies aimed at maintaining or improving bone health.

SOURCES: Journal of Hepatology 2000; 33: 812-17 (J. A. Solís-Herruzo, G. Castellano, I. Fernández, R. Muñoz, & F. Hawkins, Depts of Gastroenterology and Endocrinology, Dept. of Medicine, Hospital Universitario "12 de Octubre", Universidad Complutense, Madrid). F.A. Sylvester, U. of Conn. School of Medicine, Connecticut Children's Medical Center, Div. of Gastroenterology and Nutrition, Hartford. M. Auletta, V. Nuzzo, F. Fonderico, M.R. Fittipaldi, S. Antonielli, & G. Lupoli, Dept. of Clinical Medicine and Cardiovascular Sciences, and Dept. of Molecular and Clinical Endocrinology and Oncology, Federico II University, Naples.

ONE MAN'S JOURNEY

from T. in B.C., a 44 year old father.

Mon, 1 Mar 1999

I feel like the most pathetic human being on the face of the planet. I have not had an income for approximately the last two years and this is taking its toll on my marriage. Comments like: "Why don't you go out and get a job?", "My family thinks you are just being lazy," "I can't afford this anymore," "How much do you need this time?" "You are always on the phone," and countless others are having an effect on my self-worth/self-esteem.

I have applied for CPP as I have: 3+ portal inflammation, 2+ lobular inflammation and 3+ fibrosis. I say this because I feel really yucky some days, and I have told my GP that there are times when there are weeks when I just can't do much of anything but rest/sleep. My specialist isn't sympathetic to my suffering, which really surprised me.

As a side note, I have been an active supporter of those in need of justice, mostly without getting paid a dime from anyone, for the better part of six years. I have advocated for those who need this, but I am unable to advocate on my own behalf. How pathetic.

I created a non-profit society and have acquired charity status, but my board is not very active in raising funds/awareness. They seem to think I can do it on my own. I have begged them for their support with regards to a fund raising committee, but so far, no action.

So I am ready to throw in the towel on everything and move and leave everything behind me. I will arrive on Tuesday, tomorrow, and inquire as to income assistance to live there. I may have to stay at Streetlink 'till I can get to income assistance and get an appointment, and then find a place to hang my hat, etc.

Anyway, that's where I am at. Thanks for asking, listening and being there for others and me, too.

T.

Sat, 17 March 2001

Thank you so much for your thoughtfulness this evening. They first discovered a mass over the right lobe in mid-January, and I'm still waiting to find out what the heck it is, over two months later. Of course, my fear is cancer, and the time frame involved, if it is. Hmm. Anyhow, I would love to go to Ron's funeral, and will, if I can work out transportation. I didn't know him, but I sure know the role he played of advocate. Again thanks to you both for your thoughtfulness.

Mon, 19 Mar 2001

I finally got a biopsy booked for tomorrow and of course I won't find out anything from the biopsy for at least a week, so that makes it almost three months. Oh well, enough whining.

Tue, 27 Mar 2001

Well, it turns out that I have liver cancer. I have to wait to see the specialist for suggested treatment options and a prognosis.

Take care, and write soon,

T.

Wed, 28 Mar 2001

Do you know of any insurance plans for the dying/seriously ill that cover minimal costs?

Thanks for all your thoughts,

T.

Tue, 29 May 2001

Just thought I would write you all who have expressed your support to me over the past few months. After many phone calls to the various doctors involved in my case, I finally went in to see my GP today and told him of my frustration. He said he would look into the delay and call me back. That was this morning. This afternoon, the Cancer Centre called me to say they had an appointment booked for me for the 14th. They said the process would involve staying in the hospital for a week. Although I am not crazy about staying in the hospital for a week, especially during a labour dispute, I am grateful that something is finally being done. It will have been four months since they first discovered the tumour.

This past week I have been calling Vancouver almost daily in an attempt to get some action but to no avail. I was feeling very frustrated with this whole affair and that is what prompted me to see my GP. My GP came through though.

At times I didn't know if I had something OR nothing to worry about due to the lack of action from the specialists involved. I mean, was I supposed to interpret the lack of immediate intervention as "my situation isn't that critical" OR "that my situation is beyond hope" OR "that the medical system is so backlogged that it takes that long to get treatment." Hmm. No one would tell me until today.

Anyway, enough whining...

Write soon everyone,

T.

Tue, 29 May 2001

Just a minor update: I had the chemoembolization and was discharged two Mondays ago (just over a week). I see the new surgeon tomorrow, as I refused to see the previous one again. I should find out tomorrow if/when I will get this tumour out of my side, quite literally, a big pain in my side after the chemo! Thanks for the info in the Bull about the Lipiodol, which they did use in my case.

There is one unfortunate thing I am complaining about these days that I thought you should be aware. That is, I wish I had been given the choice of either chemo or surgery, which I was not. My first cancer surgeon told me he would not "touch me until I had the chemoembolization." If I had the choice, I would have elected to avoid the pain and discomfort of chemo and chosen the surgery. At least then, I would have only suffered once, not twice. Don't we have patient rights when it comes to treatment options? We should have!

Fri, 15 Jun 2001

Sorry I didn't get back to you earlier but I completely forgot about it. You can write about my experience in whatever manner you have the energy for - 'cause I have no energy for such things at all any more. I can tell you this, though. I would never do chemo again. It completely took away my quality of life, which is only now coming back, after 4 weeks! I have cirrhosis anyway, so if the cancer doesn't get me the cirrhosis will, so to heck with chemo.

My new cancer surgeon is a wonderful, thoughtful man. He is younger, my guess is about forty-ish, which is just fine by me. I have CT Scan planned for July 24th, which should tell me definitively, whether the surgeon can go ahead and remove the tumour as planned sometime in August.

Thanks for asking,

T.

WARNINGS

OH, NO! MILK THISTLE

Many of us Hep C sufferers have been depending on milk thistle to keep our livers from further damage. It is has been found that it contains antioxidants and lowers liver enzymes. The problem that researchers at the University of Pittsburgh discovered is that, when the liver enzymes (specifically, CYP3A4) are reduced by even small amounts of milk thistle, many substances we eat or drink, including medications, are not digested so fast and stay in the blood longer than expected.

Here is a short list of medications that may be made more or less effective by using milk thistle: methadone, heart drugs (flecainide, propafenone), antibiotics (erythromycin, rifampin), anti-seizure drugs (carbamazepine), antidepressants (St. John's wort, Wellbutrin, Paxil, Prozac, Luvox Serzone, Zoloft, Effexor), antihistamines (Hismanal, Seldane), antifungals (itraconazole , Ketoconazole), gastrointestinal motility agents, ergot drugs, antipsychotics (clozapine, pimozide), sedatives (Ambien, Halcion, Versed, Ativan), lipid-lowering drugs (statins), transplant drugs (cyclosporine, tacrolimus), anti-parasite drugs, estrogen.

Further research on these interactions can help find combinations of herbs and drugs that can be safely used together. Please tell your doctor if you are using herbs.

Source: http://www.catie.ca/aidsinfo.nsf/ June 12, 2001, A warning about milk thistle and drug interactions

SOY SAUCE PRODUCTS IN UK

The Food Standards Agency in the UK has warned consumers that almost 25% of some soy sauce products they tested last year contained high levels of a potentially cancer-causing contaminant, 3-MCPD. About 2/3 of these products also contained 1,3-DCP, which is dangerous at any level, and also can cause cancer. These products, found mostly in oriental food shops, were imported from Thailand, China, Hong Kong, and Taiwan. Some of the products are believed to be counterfeit. The products are being removed from the shelves, even though occasional consumers would probably not be affected. Soy sauce can be produced without the contaminants.

http://www.foodstandards.gov.uk/press_releases/uk_press/2001/pr010620.htm, Food Standards Agency 25 June 2001, Some potential cancer-causing soy sauce products to be removed.

NICOTINE

This study biopsied 310 Hep C patients. 176 were current smokers (who were more often males, younger, alcohol consumers, and more often had a history of IVDU than those who had never smoked.) The results were adjusted to consider these factors. The authors concluded that "**Smoking increases the severity of hepatic lesions in patients with chronic hepatitis C**."

Source: HEPATOLOGY 2001;34:121-125, Cigarette smoking and hepatic lesions in patients with chronic hepatitis C

NEFAZODONE LINKED TO LIVER DAMAGE

OTTAWA (CP)--People taking the antidepressant drug Nefazodone should be watchful for signs of liver damage, says Health Canada.

The department said the medication, sold under the trade names Serzone, Lin-Nefazodone and Apo-Nefazodone, has been linked to cases of jaundice, hepatitis and liver failure.

The drug, which has been available in Canada since 1994, did not produce such problems during clinical trials before it went on the market, the department said.

Of an estimated 650,000 patients treated with the drug in Canada, there have been four reported cases of liver failure, two of which required transplants.

Source: Times-Colonist (Victoria, BC) Tues July 10, 2001

NEWS

LEVOVIRIN

On July 2, 2001, Roche announced that it has licensed the rights to the compound Levovirin, a promising drug developed by ICN for the treatment of hepatitis C. Levovirin is a drug similar to Ribavirin, also produced by ICN.

Roche is doing clinical trials with Pegasys, a pegylated version of interferon alpha 2a. Hoping for more success, the company will be combining Pegasys with Levovirin.

In initial studies, Levovirin shows activity like that of Ribavirin, but with less side-effects. It has proven to be less toxic in animal and cell studies, and it looks like it doesn't cause anemia, like Ribavirin does. The combination of Pegasys plus Ribavirin has resulted in the highest sustained virological response ever recorded for Hep C patients, in Phase III clinical trials reported in May.

The Phase I clinical trials with Levovirin began in February 2001.

Let's hope that Levovirin doesn't get bundled…

Source: ICN Pharmaceuticals, Inc., http://www.icnpharm.com

(**DDW**—*Continued from page 1)*

times better) response rates than the general public. The author also concluded that both compliance and the use of ribavirin along with IFN are necessary to enhance responses rates of African Americans with HCV.

Predicting Response to Therapy

More good news on Pegasys: In clinical trials, doctors have discovered that, if a patient becomes HCV negative or has a 2-log drop in HCV at week 12 on treatment, it is extremely likely that he/she will become a sustained virological responder. Additionally, evidence suggests that if a patient takes 80% of his/her medicine that he/she is much more likely to clear HCV than those that do not. More studies are needed to refine this observation. Perhaps even less compliance may be beneficial. Of course, this is for elimination of virus. Studies are showing that, even if someone does not go virus negative, he/she may have improvement in liver health—so the ethical dilemma is—if a patient does not go virus negative at week 12, should therapy be discontinued or should he/she be allowed to remain on therapy in the hope that the health of the liver is improved?

The perfect scenario would be for a patient to go virus negative and have improved liver health. Most patients I have talked with about this subject would definitely prefer improved liver health over viral elimination, especially those patients with advanced disease.

It is hoped that the patient will have the opportunity to provide feedback to his/her medical provider, and maintain an active role in the decision-making process since liver health may actually be more important for some patients than viral elimination.

Other predictors of sustained virology response include patients that have genotype 2 or 3, low viral load, age less than 40 years old, low fibrosis score, lower body weight, and female gender.

Acute HCV Infection

Acute HCV infection has not been studied that closely. The difficulty has been because most people (75%) that contract HCV do not present outward symptoms.

A study from Germany by Jaeckel and colleagues treated 43 people with acute HCV with interferon. Patients were given 5 mu of interferon daily for 4 weeks, followed by 20 weeks of treatment with interferon 3 times a week.

The control group consisted of 40 patients seen at the University of Bari in Italy be-

(Continued on page 8)

TREATMENT

By Karolyn Sweeting

IFN + ESTROGEN FOR POST MENOPAUSAL WOMEN

A study was conducted at Loyola University in Chicago to determine whether the response rate to interferon (IFN) differs between pre- and post-menopausal women on estrogen replacement therapy. 26 pre- and 30 post-menopausal women (12 on estrogen replacement therapy) with chronic hepatitis C were tested. The end of treatment response for patients not on hormone replacement therapy was 80% in pre-menopausal and 38% in post-menopausal women. The sustained response observed 6 months after the therapy was 28% for pre- and 12% for post-menopausal women. The response rate to IFN was 50% for post-menopausal women on estrogen replacement therapy. The response six months after the therapy was 30%. Age, a predictor of a response to IFN, was significantly higher in pre-menopausal (75%) versus post-menopausal (62%) women. The response rate to IFN for chronic hepatitis C is influenced by estrogen status, and **estrogen replacement therapy enhances the response rate to IFN therapy**.

Source: Jules Levin, NATAP - www.natap.org, AASLD Conference: New Therapeutic Strategies for Hepatitis C, Chicago, June 15-16

BIOPSY ALTERNATIVE?

Portal flow velocity (PFV) was tested after administering glucagon chloride (a hormone that raises the level of sugar in the blood) in 45 patients with chronic HCV infection using Doppler sonography. Patients were divided into three groups: group 1 (no or mild liver fibrosis), group 2 (moderate to severe liver fibrosis), and group 3 (liver cirrhosis). All patients were examined using Doppler ultrasound 10 min. before, as well as 5 and 10 min. after the administration of glucagon chloride. Initially, there weren't any significant differences found in the PFV of any group. Five minutes after the injection, all three groups showed a significant increase in PFV. The mean increase of PFV was significantly higher in group 1 than in groups 2 or 3. An inverse correlation was found; an individual with a low level of fibrosis had a higher increase in their PFV levels, so the speed of the blood through the portal vein (after giving glucagon chloride) can indicate the amount of damage in the liver. **This may be a biopsy substitute**.

Source: Sereno S, et al, Ultrasound Med Biol 2001 May;27(5):723

TRANSJUGULAR KIDNEY/LIVER BIOPSY FOR TX PATIENTS

It is common to see patients with both liver and kidney disease, so kidney biopsies might be prudent for determining the exact cause of a kidney disease before a liver transplantation for advanced liver disease. Some patients with liver and kidney ailments are best served by receiving both a liver transplant and a kidney transplant.

Dr. Van Thiel from Loyola University Medical Center in Maywood, Illinois collected on average 19.4 glomeruli per transjugular kidney biopsy in 28 patients. 25 of these patients underwent a liver biopsy. Of that group, 15 had end-stage cirrhosis and 10 had clinically advanced liver disease from alcohol abuse or hepatitis. Few significant complications were encountered; four patients experienced a slight reduction in hemoglobin and five patients showed a slight increase in serum creatinine.

The transjugular renal biopsy technique appears to be the procedure of choice with high-risk patients with liver disease and kidney abnormalities, especially if performed together with the transjugular liver biopsy.

Source: Am J Kidney Dis 2001;37:1144-1151,1304-1307.

(DDW—*Continued from page 7)*

tween 1995 and 2000. This group did not receive interferon therapy. 97% of the patients treated with interferon cleared the virus, compared to 30% of the untreated group (they cleared the virus on their own). The authors concluded that, for patients with acute HCV infection, treatment with interferon is safe and effective and prevents the development of chronic HCV and disease progression.

These are but a few of the most interesting reports and presentations that were discussed during the DDW conference. The next 'important' conference for the HCV scientific field is the American Association for the Study of Liver Disease, which takes place in Dallas, TX, November 9-13, 2001. Look for more reports in advances in the understanding and treatment of HCV from this conference.

CLINICAL TRIALS

ANOTHER LOOK AT ALTs

There have been many articles stating that the ALT test is not a good indication of the state of the liver in cases of Hep C infection. The doctors in this study took a new look at the ALT in 80 patients with persistently normal ALT (PNALT) compared to 455 patients with elevated ALT and calculated progression rates. There were more women than men in the PNALT group, and there were more genotype 1 patients in the second group than in the first. Cirrhosis was less frequent in the PNALT group. The Knodell score showed much **less damage and slower fibrosis progression in the PNALT group**.

Source: Herve S, et al., Eur J Gastroenterol Hepatol 2001 May;13(5):495-500 Chronic hepatitis C with normal or abnormal aminotransferase levels: is it the same entity?, PMID: 11396527, UI: 21289481

ISIS 14803 IN NON-RESPONDERS

HepaSense, Ltd., producers of ISIS14803, has announced the results of a phase I/II clinical trial with 11 people infected with HCV, all non-responders to previous IFN mono or combo therapy, except one, and all genotype 1. The patients were given increasing doses of up to 2 mg/kg intravenously of ISIS 14803, three times a week, for one month.

Responses, probably dose-dependent, developed after several doses of ISIS 14803, and lasted for 20-50 days. In most cases, responses were associated with a temporary ALT flare. ISIS 14803 was well tolerated. Adverse events reported were minor and non-specific. Liver biopsies performed on 2 experiencing an ALT flare revealed no evidence of drug induced liver damage. More studies are being done with subcutaneous injections.

Source: AASLD Conference: New Therapeutic Strategies for Hepatitis C, Chicago, June 15-16, 2001, Reported by Jules Levin, www.isip.com

PHASE I CLINICAL TRIAL WITH XTL-002

XTL-002, produced by XTL Biopharmaceuticals, is a monoclonal antibody whose target is the HCV envelope protein. It recognizes many different genotypes. In preclinical trials, XTL-002 decreased HCV load by greater than 90% in the HCV Trimera model. XTL has begun phase I trials in Israel, with 15 HCV infected patients, as of July 2001.

Source: www.xtlbio.com/background.html, www.prnewswire.com 07/03/2001 XTL Biopharmaceuticals Initiates Phase I Clinical Trial with XTL-002 for Hepatitis C

MY TAKE

by Bruce Devenne

Today the Hamm Government, amid a cloud of quickly written spin doctor speeches, gave in to the nurses, and said they would go to a form of binding arbitration, something the nurses wanted weeks ago, and to which the government would not agree.

The Premier and his sidekick Muir appeared today and tried to give it a pro-government spin, but they have been beaten. The law C68 will be removed in the near future.

I've said it before and I'll say it again: If you want to be counted and listened to, you have to be pro-active. Speak up, show up, carry a picket sign. The nurses did this because they are united, not divided off in camps inside and outside windows as to when they were hired, camps as to how they were hired, or when or why they were hired. They are represented by organizations with no strings to government, who fought only for them as a solid unit with nothing to gain by accepting less than equal and fair treatment for each and every one of the members.

If you want to get somewhere in this country you have to be united and noisy. Otherwise the elected dictators will simply make deals left right and center, and screw as many of you as they can.

Ottawa didn't spend years on giving themselves yet another raise. They didn't have to strike (Who would care?) Why are we treated differently from the people who WORK FOR US?

It can be done, but not from the quiet, secure, private armchair in your living rooms.

(DAVE LANG—*Continued from page 1)*

value of education and support.

For the past five years David had served as the vice-president of the board of directors of the Hepatitis Education Project (HEP), a Seattle-based hepatitis support and education organization. He was also on the HEP education committee. In 1998 he appeared on KOMO TV in Seattle with another HEP board member and two physicians, all of whom were interviewed about hepatitis C. He interviewed and videotaped four patients, and the video was shown on public access television in 1999. David also took a grant-writing course and subsequently authored several grant proposals for HEP, at least one of which resulted in a sizeable grant. He also authored a FAQ for hepatitis C, which is published by the Hepatitis Education Project.

David was born in Yakima, Washington on March 9, 1950 and graduated from A. C. Davis high school there in 1968. During his school years he lived for a time in Bothell, Washington. After he graduated from high school, he joined the Air Force and spent most of his service time at Keesler AFT in Mississippi, where, in 1977, he received a series of awards and commendations from the Air Force for superior knowledge and ability, professional skill, duty performance and exemplary conduct.

For the past 15 years David was employed by SITA-Equant International Telecommunications as the manager of the Seattle office, and had recently completed a training course in the operation, function and maintenance of Cisco routers.

His other passion, besides his wife, his cats and his education activities, was fishing. David knew the best places to fish in the entire state, and went whenever he could. His email address was, in fact, "hepfisher@..."

Survivors include his loving wife Alice, his stabilizer and anchor, who supported him in all his various activities; his mother, Karey Keath of Sedro Woolley, Washington; his adoptive father, James Lang, of Arlington, Washington; and numerous other relatives.

The family requests that, in lieu of flowers, donations be made to the Hepatitis Education Project, 4603 Aurora Ave N, Seattle, WA.

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: Carol Anton or Jeanette Cheung
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

THIS SERVICE, USUALLY PROVIDED 24 HOURS A DAY FREE OF CHARGE BY LESLIE GIBBENHUCK, HAS BEEN SUSPENDED DUE TO NON-RENEWAL OF HEALTH CANADA-FUNDING.

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/YUKON:

Armstrong HepCure Office and library, by appointment. Contact: Marjorie, 546-2953, amberose@sunwave.net, www.junction.net/hepcure

Castlegar Contact: Robin, 365-6137

Chilliwack BC HepTalk Meetings: 2nd & 4th Wed. monthly, 7-9 PM, Chilliwack. Next meetings: Aug. 8th & 22nd. Contact: 856-6880.

Comox Valley HeCSC Meetings: 3rd Tues. monthly, 7-9 PM, St. George's United Church on Fitzgerald. Next meeting Aug. 21st Contact: Jayne, 336-2485 or Dan, 338-0913, Rhagen@mars.ark.com

Cowichan Valley Hepatitis C Support Contact: Leah, 748-3432.

Cranbrook HeCSC : Meetings: 1st & 3rd Tues. monthly, 2-4 PM, #39 13th Ave South, Lower Level. Next meetings Aug. 7th & 21st. Contact: 426-5277, hepc@cyberlink.bc.ca

Creston/Golden/Invermere Educational presentation and appointments: Contact Katerina 426-5277

Grand Forks Hep C Support Centre Each Mon, 3:30-5:30 PM, & 1st Mon. monthly, 6:30 PM, 7215 2nd St. (Boundary Women's Resource Centre) Contact Ken, 1-800-421-2437

HepCBC INFO Line. Free medical articles or other info. Contact: David, (250) 361-4808, info@hepcbc.org, www.hepcbc.org

Kelowna HeCSC Meetings: 1st Sat. monthly, 2-4 PM, Rose Avenue Education Room, Kelowna General Hospital. **(Please call as Room may change) NO MEETINGS JULY/AUG**. Contact Elaine Risely (250) 768-3573 or Barbara-J., 862-2437.

Kimberley Support Group Meetings: 1st Mon. monthly, 1-3 PM. Next meeting Aug. 6th. Contact Katerina 426-5277

Kootenay Boundary Meetings: 2nd & 4th Tues. monthly, 7 PM, 1159 Pine Ave, Trail. **No Summer meetings.** For individual support, info & materials, contact: Brian, 368-1141, k-9@direct.ca.

Mid Island Hepatitis C Society Meetings: 2nd Thurs. monthly, 7 PM, Central VI Health Centre 1665 Grant St, Nanaimo **Contacts—Ladysmith:** Sue 245-7635 mihepc@home.com **Nanaimo:** Barb 756-9631 bwreggitt@home.com

Mission Hepatitis C and Liver Disease Support Group Meetings: 3rd Wed. monthly, 7 PM, Springs Restaurant, 7160 Oliver St. Next meeting Aug. 15th. Contact Gina, 826-6582 or Patrick, 820-5576. missionsupport@eudoramail.com

Nakusp Support Group Meetings: 3rd Tues. monthly, 7 PM, Nakusp Hospital Boardroom. Next meeting: Aug. 21st. Contact: Ken, 1-800-421-2437

Nelson Hepatitis C Support Group Meetings: 1st Thurs. monthly. ANKORS Offices, 101 Baker St., Next meeting: Aug. 2nd. Contact: Ken Thomson, 1-800-421-2437, 505-5506, info@ankors.bc.ca, or Ken Forsythe 355-2732, keen@netidea.com

New Westminster Support Group Meetings: 2nd Mon. monthly, 7-8:30 PM, First Nations' Urban Community Society, Suite 301-668 Carnarvon Street, New Westminster. Next meeting Aug. 13th. Contact: Dianne Morrissettie, 525-3790.

Parksville Support Group Contact Ria, 248-6072

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 Contact: Leslie, 490-9054, bchepc@telus.net

Powell River Hep C Support Group: No meetings over the summer. Social evening September 12th. Contact number for the summer: Cheryl at 483-3804, or the Health Unit at 485-8850.

Prince George Hep C Support Group Meetings: 2nd Tues. monthly, 7-9 PM, Health Unit Auditorium. Next meeting Aug. 14th. Contact: Gina, 963-9756, gwrickaby@telus.net or Ilse, ikuepper@nirhb.bc.ca

Princeton Meetings: 2nd Sat. monthly, 2 PM, Health Unit, 47 Harold St. Next meeting Aug. 11th. Contact: Brad, 295-6510, citizenk@nethop.net

Queen Charlotte Islands/Haida Gwaii: Phone support. Contact Wendy: 557-9362, e-mail: wmm@island.net

Quesnel: Meetings last Mon. evening every other month. Contact Elaine Barry, 992-3640, ebarry@goldcity.net

Richmond: Lulu Island AIDS/Hepatitis Network: Meetings/drop-in dinner each Mon. 7-9 PM. Contact Phil or Joe, 276-9273.

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

Smithers: Positive Living North West Meetings: 2nd Wed. monthly, 7-9 PM, 3731 1st Avenue, Upstairs. **No Meetings July/Aug.** Contact: Deb. 877-0042, 1-866-877-0042, or Doreen, 847-2132, plnw_hepc@bulkley.net

Sunshine Coast—Sechelt: Contact: Kathy, 886-3211, kathy_rietze@uniserve.com—**Gibsons**: Contact Bill, pager 740-9042

Vancouver HepHIVE: Contact: 254.9950 hephive@mdi.ca **Meetings:**

- **Carnegie Centre** Hep C & HIV/HCV Meetings: Each Mon., except holidays, 4:30-6 PM, 3rd floor, room. 2.
- **HepHIVE and HepC VSG** Hep C & HIV/HCV Meetings: Last Wed. monthly, 10:30-12:30, BCCDC Building, 655 West 12th Tom Cox Boardroom 2nd floor. Next meeting Aug. 29th.

VANDU Vancouver Area Network of Drug Users Meetings each Mon., 1 PM, #350 - 163 West Hastings St., (Cambie & Hastings) Bus fare and snack. Contact: Ed or Ann, 683-8595, vandu@vandu.org, annlive@direct.ca, www.vandu.ca

Vernon HeCSC HEPLIFE Meetings: 2nd & 4th Wed. monthly, 10 AM-1 PM, The People Place, 3402-27th Ave. Next meetings Aug. 14th & 28th. Contact: Sharon, 542-3092, sggrant@netcom.ca

Victoria HeCSC Meetings: 1st Mon. monthly, 6:30-9 PM, CHR 1947 Cook St. Multi-Purpose Room and last Wed., St. John's, 1-3 PM. Contact: 388-4311, hepcvic@coastnet.com

Victoria Support and Discussion Group Meetings: 1st Wed. monthly, 7-9 PM, Next meeting Aug. 1st. Contact Hermione, Street Outreach Services 384-1345, hermione@avi.org

Victoria HepCBC Support Groups Small support groups for men or women. Men, contact David at 361-4808, cdm@hepcbc.org Women, contact Joan at 595-3882, or jking@hepcbc.org

Yukon Positive Lives Meetings: 3rd Wed. monthly , Whitehorse. Next meeting Aug. 15th. Contact 456-2017, positivelives@yknet.yk.ca or Heather, fromme@marshlake.polarcom.com, www.positivelives.yk.ca

OTHER PROVINCES

ATLANTIC PROVINCES:

Atlantic Hepatitis C Coalition, QEII Health Sciences Centre, Bethune Building, Rm 223, 1278 Tower Road, Halifax, TEL: 420-1767 or 1-800-521-0572, rahcc@ns.sympatico.ca, www.ahcc.ca **Meetings:**

- **Antigonish:** 2nd Wed. monthly, 7 PM, St. Martha's Health Centre, 25 Bay St, Level 1 Conference Room
- **Bridgewater:** Last Wed. monthly, 7 PM, South Shore Regional Hospital, 90 Glen Allen Dr., Private Dining Room
- **Halifax:** 3rd Tues. monthly, 7 PM, QEII Health Sciences Centre, 1278 Tower Rd, Dickson Bldg, Rm 5110
- **Kentville:** 2nd Tues. monthly, 6:30 PM, KingsTech Campus, 236 Belcher St, Rm 214
- **Truro:** Last Tues. monthly, 7 PM, Colchester Regional Hospital, 25 Willow St, Conference Room
- **Yarmouth**: 1st Tues. monthly, 7 PM, Yarmouth Regional Hospital, 60 Vancouver St, Lecture Room 1—Main level

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

Greater Moncton, N.B. HeCSC Contact Debi, 1-888-461-4372 or 858-8519, monchepc@nbnet.nb.ca

Saint John & Area/HeCSC: 3rd Thurs. monthly, 7 PM, Community Health Centre, 116 Coburg Street. Contact Esmonde, 653-5637, hepcsj@nb.aibn.com, www.isaintjohn.com/hepc/

ONTARIO:

Durham Hepatitis C Support Group Meetings: 2nd Thurs. monthly, 7 PM, St. Mark's United Church, 201 Centre St. South, Whitby. Aug 9th. "Healthy Diet for the Liver." Speaker: Dianne Elliott, Public Health Nutritionist, Durham Region Health Dept. www.region.durham.on.ca/ Contact: Smilin Sandi, smking@home.com http://members.home.net/smking/index.htm, Ken Ng , (905) 723-8521, or 1-800-841-2729 (Ext. 2170)

Hep C Niagara Falls Support Group Meetings: Last Thurs. monthly, 7 PM, Niagara Regional Municipal Environmental Bldg., 2201 St. David's Road, Thurold. Contact: Rhonda, (905) 295-4260 , Joe (905) 682-6194 or hepcnf@becon.org

HepSEE Barrie Chapter Meetings: 3rd Tues. monthly, 7-9 PM, AIDS Committee of Simcoe County, 80 Bradford Street, Suite 336 Contact: Jeanie, 735-8153 hepseebarrie@home.com

Kitchener Area Chapter Meetings: 3rd Wed. monthly, 7:30 PM, Cape Breton Club, 124 Sydney St. S., Kitchener. **NO MEETING AUG.** Contact: Carolyn, 893-9136 lollipop@golden.net

Windsor Support Group Meetings: Each Thurs.., 7 PM, 1100 University Ave. W. Contact 739-0301 or Ruth or Janice (Hep-C), 258-8954, truds99@hotmail.com

PRAIRIE PROVINCES:

Edmonton, AB Hepatitis C Informal Support Group Meetings: 3rd Thurs. monthly, 6 PM, 10230-111 Avenue, Conference Room "A" (basement) Contact: Jackie Neufeld, 939-3379

Edmonton, AB Meetings: 2nd Wed. monthly , #702-10242 105 St. Contact Fox, 488-5773, 473-7600, or fox@kihewcarvings.com

HepSEE WPG Winnipeg Meetings: Each Wed.., 7-9 PM, Young United Church, 222 Furby St., Rm AB, Main Floor. Contact: 774-8123, bbuckels@escape.ca

QUEBEC:

Hepatitis C Foundation of Quebec Meetings: 4th Tues. monthly, 7-9 PM, Montreal General Hospital, room A1.109, 1650 Cedar Ave. 7-9 PM., and 3rd Wed. monthly, 2-4 PM, 4341 Verdun Ave. Contact Eileen to reserve (limited seating): 769-9040 or fhcq@qc.aibn.com