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Canada's Hepatitis C News Bulletin

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HEP C CIRCLE: JOINING FORCES

The BC Hepatitis C Collaborative Circle and the HeCSC BC Chapter Network met in October for two days to talk about the future. The two organizations agreed in principle that they need to speak with one voice on common issues that affect people with hepatitis C in BC.

Otherwise, policy makers and politicians will continue to use the old excuse that the community is divided, so nothing can be done.

Two Chapter Network representatives will work with the Hub (Circle working group) to develop a constitution and by-laws for a new Society. The challenge is to maintain individual organizational autonomy while making sure that mechanisms are in place to assist developing groups with capacity building.

The joint conference agreed on a set of core elements for a Canadian Hepatitis C Strategy. Those core elements are being made available to community-based organizations across Canada, with the hope that they will review and add to them. This information will be gathered and presented at the 2nd Canadian Hepatitis C Conference in Vancouver on March 27, 2004.

Other Conference Proceedings

Suzanne Solven of Pharmacare spoke about how Pharmacare operates and addressed issues about Pegetron criteria. Unfortunately, her answers seemed to run in circles and many in the audience had trouble seeing the scientific validity of those criteria.

She did say, however, that if patients seeking treatment had normal ALT levels but biopsy results showed significant liver disease, their physicians could apply for exceptions.

(Continued on page 5)

AASLD CONFERENCE FAVORITES

BILN 2061

BILN 2061, an HCV protease inhibitor, was tested for 2 days in 10 genotype 1 patients with cirrhosis. Viral load was reduced up to 3 log 10 copies/ml., and the dose was well tolerated.

Because of the short treatment time in this study, researchers were not alarmed that the virus did not disappear completely.

Poster 294: Heiner Wedemeyer et al.

VX 950

HCVNS3-4A protease inhibitor VX 950 has been identified as a treatment candidate for HCV infection.

"The anti viral activity can be sustained in viral clearance assays resulting in a continuing decline of HCV RNA for 9 days," researchers said.

Clinical trials are planned for early 2004.

Poster 972: VX-950: Robert B Perni et al.

RIBAVIRIN DOSE REVIEWED

The ribavirin dosage should possibly be reconsidered according to the patient's weight.

343 treatment-naïve patients were given IFN alfa-2a plus ribavirin, and half were also given amantadine.

"The SVR rate was 66% in patients

(Continued on page 6)

INSIDE THIS ISSUE:

MEET HepCBC'S NEW EXECUTIVE DIRECTOR

HepCBC Executive Director's Report – October 2003

by Neil Tayor, Executive Director, HepCBC

Greetings!

During the past months I have been very impressed with the work done by HepCBC. The individual support provided, the web site, and *hepc.bull* are remarkable contributions to assist those impacted by HepC in the Victoria community and to a degree in BC and beyond.

I am steadily getting up to speed on Hep C and on programming and initiatives available to people affected by it. There remains a longgggggg way to go!

I would like the board to consider two things that have become apparent to me from my efforts to date—specifically:

1. the need for a legitimate, formal, BC-based Hep C Society to lobby government and tie together all the diverse (and diverse is GOOD!) provincial initiatives.
2. the need for all key agencies and organizations from the south part of Vancouver Island to come together and to continue to regularly liaise. The immediate purpose of this would be to identify service gaps and overlaps and better coordinate our overall efforts. It very much reflects what I think is required in (1) above, but translated to the local scene.

There are too many people with unmet, or poorly met, needs to not proceed in this manner. We need also to be cogni-

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LETTERS TO THE EDITOR:

The *hepc.bull* welcomes and encourages letters to the editor. When writing to us, please let us know if you do not want your letter and/or name to appear in the bulletin.

Peppermint Patti's FAQ Version 5.6 Available NOW!!

Peppermint Patti's FAQ Version 5.6 is now available in English and Spanish. The English version includes updated Canadian Links and both include the latest TREATMENT INFORMATION. Place your orders now. Over 100 pages of information for only $5 each, plus postage—but if you can afford more, we'll take it. Contact HepCBC: (250) 595-3892, info@hepcbc.ca

HepCBC Resource CD: The CD contains back issues of the *hepc.bull* from 1997-2003; the FAQ V5.6; the Advocate's Guide; the slide presentations developed by Alan Franciscus; and all of HepCBC's pamphlets. 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!!

HepCBC would like to thank the following institutions and individuals for their generosity: The late John Crooks, Bryce Brogan, Bruce Lemer, Lexmark, Health Canada, Pacific Coast Net, Margison Bros Printers, Royal Bank, Schering Canada, Merv Adey, Brad Kane, Arlene Darlington and friends, Chris Foster, Darlene Morrow, Will Lawson, Judith Fry, Ron Comber, and Stacey Boal. Heartfelt thanks to Blackwell Science for a subscription renewal to gastrohep.com

Special thanks to Roche Canada for an unrestricted grant to help publish this newsletter!

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. Joan, #5-915 Glen Vale Rd, Victoria BC V9A 6N1, (250) 595-3892.**

Give us your name, tel. no., and address.

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

CONFERENCES

February 27-March 1, 2004
Canadian Digestive Disease Week
Banff Springs Hotel, Banff, Alberta

February 26 - March 5, 2005
Canadian Digestive Disease Week
Banff, Alberta

September 12, 2005
WCOG Conference - 14th Annual Meeting - World Congress of Gastroenterology: Montreal. Quebec

March 4 - 12, 2006
Canadian Digestive Disease Week
Quebec City, Quebec

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.

PREPLANNING YOUR FINAL ARRANGEMENTS?

Please consider arranging for donations to your local hepatitis C organization.

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Got Hep C? Single? Visit:

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ABSTRACTS FROM THE 2003 EASL CONFERENCE* *by Will Lawson*

**Summaries of selected abstracts from the European Association for Studies of the Liver (EASL) Conference held July 3-6, 2003 in Geneva, Switzerland. Source: www.hcadvocate.org (click on the Liver Meeting graphic).*

CHRONIC HEP C AND STRESS

France: A diagnosis of HCV was considered as the most stressful event after the death of a loving person and a divorce. It was significantly more stressful than a dismissal and a move. Stress scores were significantly higher in women. Stress was related to self-perceived rather than to actual severity.

185 consecutive HCV RNA-positive patients were asked to self-grade, and anxiety was assessed using the Spielberger State Trait Anxiety Inventory.

GLYCYRRHIZIN THERAPY

Japan: Glycyrrhizin (SNMC) therapy reduces the risk for development of HCC (liver cancer) in chronic hepatitis C patients with fibrosis stage 3 or higher, not responding to IFN therapy.

All consecutive chronic hepatitis C patients from 12 Japanese university and major general hospitals, who received IFN between 1990 and 1995 without a sustained response, were included (1093). The median follow-up was 6.1 years.

Glycyrrhizin (SNMC) is used as a treatment for patients with hepatitis C in all academic units in Japan.

TRIPLE THERAPY FOR HEP B/C COINFECTION

Germany: Consensus Interferon (CIFN) daily dosing therapy together with lamivudine and ribavirin triple therapy showed promising response rates in this pilot study.

After 36 weeks of triple therapy, a negative HBV PCR was observed in 78% and a negative HCV RNA was observed in 72%. Patients completing treatment and 24-week follow-up showed response rates of 69% (ETR) and 56% (SR), for HCV. For HBV, 81% of patients so far reached a viral response at end-of-treatment.

21 patients (mean age 51.3 yrs, all with elevated ALT and viremia for HBV and HCV, all genotype 1) were studied. Treatment started with 12 weeks of lamivudine monotherapy, then CIFN and ribavirin was added for another 60 weeks.

MULTIPLE HCV GENOTYPES AND RESPONSE TO IFN

California:

- Multiple genotypes is common. Patients with 1 or 2 genotypes were found to have between 2 and 4 genotypes. In some, IFN therapy resulted in detection of additional genotypes not observed at baseline.
- NR demonstrated persistence of multiple genotypes during therapy and at follow up.
- Sustained response determined by commercial assays may represent sustained suppression of virus rather than clearance. This may explain the development of late relapse.
- Host responses to virus and presence of multiple HCV genotypes may represent important factors associated with non-response.

Four sustained responders, 4 relapsers and 4 nonresponders were selected. Primers specific for 6 genotypes and 9 subtypes were used to amplify the core region. Extended PCR (45 cycles) was used.

RESPONSE TO COMBINATION THERAPY OF OCCULT HEP B VIRUS

Italy & England: HBV DNA is frequently found in the liver of patients with chronic hepatitis C. However, the lack of any significant impact on HCV viral titre, liver enzymes, histological parameters, and response to therapy suggests that in most cases HBV DNA detected in the liver by PCR may be either an integrated or low level replicative form.

Liver biopsies and serum samples were collected from 51 patients with HBsAg negative chronic hepatitis C, and tested for HBV-DNA with nested PCR. Twenty-five were treated with alpha Interferon plus ribavirin and followed for at least 18 months.

PEGASYS VS PEG-INTRON

Italy: The investigators concluded: "Our data demonstrate substantial differences in plasma concentration profiles between PEGASYS and PEG-Intron. Five days after injection concentrations of PEG-Intron are marginal or undetectable, while those of PEGASYS remain stable overtime.

"These findings suggest that PEG-Intron administration should be intensified to twice weekly to avoid "blips" in viral replication. Differences in pharmacokinetics could explain the differences observed in HCV decay."

30 treatment naive patients with CHC and persistently elevated ALT levels were randomized to receive 180 mcg PEGASYS once-weekly or 1.0 mcg/kg once-weekly of PEG-Intron.

Serum concentration of PEG-Intron achieved maximum levels at 24 hours after injection and decreased rapidly until 120 hours. Drug was undetectable 120 and 168 hours after injection in 7 (50%) and 11 (78%) subjects, respectively. In contrast, PEGASYS concentrations increased continuously overtime, reaching maximum levels from 48 to 168 hours.

HIGH HCV VIRAL LOAD, GENOTYPE 1, & CIRRHOSIS MAY NEED MORE THAN 48 WEEKS

More than 48 weeks treatment for CHC patients with high baseline viral loads, HCV genotype 1, and cirrhosis may be necessary and should be investigated.

1375 chronic HepC patients received Pegasys 180 mcg/week plus ribavirin 800-1200 mg/day for 24 or 48 weeks. At follow up, high baseline viral load, and, to a lesser degree, cirrhosis, were found to be associated with relapse, particularly in HCV genotype 1 patients.

PEGASYS + AMANTADINE POSSIBLE ALTERNATIVE

Italy: Treatment was more effective with Pegasys + RBV than with Pegasys + AMA, especially among the difficult-to-treat patients (genotype 1, 4). If these primary virological response rates will translate into corresponding sustained rates, an effective alternative combination regimen will be in place for those patients who can't tolerate RBV or when it is contraindicated.

734 HCV-RNA positive naïve patients with raised ALT and biopsy-proven chronic HepC were studied. 28% of them were cirrhotics, and 58% were infected by HCV genotype 1 or 4. The ongoing study randomizes 180mcg once weekly of Pegasys with RBV or AMA for 48 weeks with a 24-week follow-up.

(Continued on page 4)

(EASL—Continued from page 3)

No severe or unexpected side effects were observed in either group. The usefulness of amantadine (AMA) as an adjunct to PEG-IFN in treating naïve patients with CHC is still controversial.

14-WEEK TREATMENT FOR GENOTYPE 2/3 INFECTION

Norway: This preliminary analysis suggests that, in patients with HCV genotype 2/3 infection who experience early HCV clearance, a high sustained response rate may be obtained after 14 weeks of combination treatment.

Preliminary results show that 80% of those who receive short combination treatment obtain sustained virological response 24 weeks after treatment.

Eight weeks or more of combination treatment has been fulfilled in 63 patients. All patients are treated with pegylated interferon alfa-2b and ribavirin. HCV RNA was negative at both week 4 and 8 in 71% and treatment is therefore discontinued at week 14 in these. The remaining 18 patients are receiving 24 weeks treatment.

PEG TRIPLE THERAPY VS. STANDARD THERAPY IN NON-RESPONDERS

France: Triple combination therapy (TCT) with IFN+ribavirin+amantadine is well-tolerated. Preliminary results suggest a potential benefit on sustained virologic response. The frequent improvement of biochemical and histological responses suggest that non-response can be often overcome. The improved efficacy/tolerance ratio of TCT makes a valuable option for maintenance therapy.

The study is still ongoing. The 204 enrolled patients were 73% males with 79% genotype 1, and had a fibrosis score < F3 (65%). Among 55 patients at 72 weeks, virological response rate was 26%.

WEEK 8 VS. WEEK 12

France: Prediction of sustained response (SR) assessed by = 2 log drop or undetectable HCV RNA might be done as early as week 2 in naïve patients and as early as week 4 in previously treated (PT) patients.

Prediction of no SR is optimal at week 8 in naive and somewhat less accurate in PT patients. The more accurate predictive values for SR were TMA negative at week 4 or EVR at week 8. Therefore treatment status should be considered when assessing a patient's response to therapy.

81 patients, 43 naive and 38 previously treated (PT), were treated with the combination of Peg-IFN alpha 2b + RIBA.

HEP C-ASSOCIATED AUTOANTIBODIES, PATHOLOGY AND RESPONSE

France: In cases of chronic HepC (CHC), patients with detectable Autoantibodies (Aabs) have more marked necroinflammatory lesions (i.e., liver damage) and less severe steatosis (fattiness). These results suggest the involvement of Th2 immune response on both necroinflammation and inhibition of steatogenesis.

Presence of AAbs was associated neither with fibrosis score nor with fibrosis progression rate (FPR). In treated patients, end-of-treatment response (EOT-R) and sustained virological response (SVR) were observed in 34% and 22%, respectively. Presence or absence of AAbs did not influence EOT-R or SVR.

439 patients with histologically-proven CHC consecutively seen between 1999 and 2001 and tested for AAbs were studied.

EFFECT OF TREATMENT ON LIVER STEATOSIS IN GENOTYPE 3 PATIENTS

France: The study found a significant improvement of steatosis (fatty liver) in genotype 3 patients achieving a SVR. This is further evidence that HCV contributes to hepatic steatosis.

After antiviral treatment, steatosis improved in 34% of cases, was stable in 51% and worsened in 15%. Steatosis improvement was significantly more frequent in patients with a sustained virological response (SVR) and in genotype 3 patients. Among the SVR, improvement of steatosis was significantly more frequent in genotype 3 patients.

125 naïve patients (34 with HCV genotype 3; 91 with HCV genotypes non-3) were selected according to the following criteria: presence of steatosis; treatment with interferon-alpha; BMI < 28 kg/m2; and absence of excessive alcohol intake.

TIME TO DEVELOP CHRONIC LIVER DISEASE IN GENOTYPE 1 PATIENTS

Istanbul: The mean time to develop chronic hepatitis (CH) and cirrhosis in this HCV genotype 1b dominant population is 16 years and 26 years respectively. The development of stage 4 CH takes 25 years while this duration for stage 1 disease is 15 years.

A total of 320 patients (57% female, mean age 49.7); 206 with CH, 67 with cirrhosis, 16 with HCC and 31 ALT normal with CH were included and questioned for transmission routes and time.

RETREATMENT: HIGH VS. CONVENTIONAL DOSES OF CIFN + RIBAVIRIN

Germany: CIFN/ribavirin treatment of patients non-responsive to previous therapies induced promising end-of-treatment results. Therapy was quite well tolerated.

Since the high dose induction regimen appeared superior for most subgroups, viral elimination rates might be further increased by daily dosing of CIFN (consensus IFN) and weight-adjusted ribavirin dosing.

94 patients (age 45 years, male 59%, cirrhosis / bridging fibrosis 64%, genotype-1 71%) with detectable HCV-RNA and elevated ALT after non-response or relapse to IFNa or IFNa/riba were studied.

PREDICTING RESPONSE IN HIV/HCV CO-INFECTION

Spain: In contrast to genotype 3, a lack of virological response is observed in most genotypes 1 and 4. A good prediction of the response at week 24 was obtained at week 12; furthermore, a qualitative test at week 12 may discriminate future relapsers.

28 patients were included. 85% had HIV RNA viral load <200cp/ml; mean baseline CD4 554.4/mm3 (225.1). All but 4 were on HAART. HCV genotypes: 13 were 1a/b, 10 were 3a, 5 were 4c/d. The global virological response at 24 weeks was 52.4% (11/21): 3a (7/8), 4c/4d (2/5), 1a/b (2/8).

LIVER DAMAGE IN CO-INFECTED PATIENTS

Europe: More advanced stages of liver fibrosis are seen in HIV-HCV co-infected patients than in HCV mono-infected patients. Overall, up to one third of those with elevated ALT levels show severe liver fibrosis (F3-F4), but this increases significantly with duration of HCV infection.

(Continued on page 5)

(EASL—Continued from page 4)

3 factors were predictors of severe liver fibrosis: duration of HCV infection >15 years, age >20 years at the time of HCV infection, and high alcohol intake. 46% of patients estimated to be infected for more than 15 years had severe liver fibrosis.

492 patients (78.5% males, 86% IVD-users, 25% alcohol intake >80g/dl) were analyzed. Median age was 35 years old. Median estimated duration of HCV infection was 14 years. Median ALT elevation was 2 fold. Antiretroviral therapy: 43%, and no drugs 57%. HCV genotype was 1: 57%, 2: 1%, 3: 36% and 4: 6.3%. 69% of patients harboured HCV-RNA > 800000 IU/ml. Liver fibrosis stage was F0: 13.2%, F1: 35%, F2: 18.7%, F3: 21.5%, and F4: 12%.

DISEASE PROGRESSION IN HEALTHY CARRIERS

France: There is no fibrosis progression in 66% of patients without significant initial histological lesion. Fibrosis progression is associated with elevated ALT, BMI >25, and years of infection. There was no difference between hepatitis activity index (HAI) or fibrosis evolution with genotype or viral load. There was a significant correlation between activity progression and fibrosis progression.

Mean age at contamination and at the first biopsy was 25 and 38 years respectively. Median duration of infection and time between paired biopsies was 13 and 4 years respectively. ALT was normal in 43.4%. 50% had progression of the hepatitis activity index (HAI) and 34% of fibrosis. The median difference of HAI and fibrosis score between biopsies was low; 1.5 and 0.0, respectively. Fibrosis progression was correlated interval between biopsies.

76 untreated HCV-infected patients with normal liver and detectable HCV-RNA were studied. Studied factors of progression included ALT, date and age at contamination, infection duration, viral genotype and load, BMI, and alcohol consumption.

COMPLIANCE AND TREATMENT IN IVDUs

Belgium & Netherlands: In this study, IVDUs (Intravenous Drug Users) showed the same compliance and response to treatment with IFN and ribavirin compared to other patients with CHC viral infection after adjusting for genotype. Therefore, it is not longer justifiable to withhold treatment to chronic hepatitis C patients who use intravenous drugs.

Of 406 patients, 98 (24%) were IVDUs. Noncompliance in IVDUs was not different from non-IVDUs. Complete response (CR) was better in IVDUs than in non-IVDUs. However, when controlling for genotype the CR was not different. Viral load did not change these results. There was no difference in SVR between IVDUs and non-IVDUs.

Greek Christmas Bread

(15 servings)

1 pk (or 1 tablespoon) Active Dry Yeast
1/4 c Warm Water (110 to 115 degrees)
1/3 c Sugar
1 tsp Ground Cardamom
1/4 tsp Salt
1 Egg
1/4 c Milk
1/4 c Vegetable Oil
1 1/2 c Whole Wheat Flour
1 c All-Purpose Flour
1/4 c Golden Raisins
1/4 c Walnuts, chopped

Instructions

Dissolve the yeast in the warm water. Combine the sugar, cardamom, salt, egg, milk and oil in a large bowl. Mix well. Add the yeast mixture, flours, raisins and nuts. Mix well. Add enough extra flour to make soft dough. Turn the dough out onto a floured surface and knead until smooth and elastic, about 5 minutes. Shape into a round loaf. Put the dough into a lightly-oiled 8-inch-round cake pan. Cover with a damp towel and let rise in a warm place until doubled in bulk, about 1 hour. Bake in a 350-degree oven 35 to 40 minutes, or until brown.

One Serving = Calories: 147 Carbohydrates: 22 Protein: 4 Fat: 6 Sodium: 40 Potassium: 101 Cholesterol: 18

http://lowfatcooking.about.com/gi/dynamic/

(BC CIRCEL—Continued from page 1)

Ms. Solven also announced that Pegasys has been submitted to Pharmacare as a monotherapy.

Dr. Sigmund Erb (UBC) spoke about studies that show that long-term (3yr.) interferon therapy decreases necrosis and fibrosis in both relapsers and non-responders. He pointed out that SVR may not turn out to be the most important goal.

Dr. Erb also spoke about the research into new drugs and combinations. We can't expect to see concrete results for at least 5 years. One interesting situation involves Colchicine, which has been around for 2000 years. It will be used in a trial vs. pegylated interferon.

VANDU (Vancouver Area Network of Drug Users) made a presentation on safe injection sites and facilitated a discussion on how their prevention and peer education successes can be used in other communities.

A workshop on understanding and writing funding proposals was presented.

Finally, two statistics of interest: There seems to be a 2-3% lifetime chance of sexual transmission, and 4.9% of men age 25-55 are HCV+.

Ken Thomson
Chairperson, Hub Team
BC Hepatitis C Collaborative Circle

(HepCBC—NEW Executive Director—Continued from page 1)

zant of the fact that overall provincial and regional health budgets are under pressure. In addition, the "special" federal funding regimens that have supported community initiatives are scheduled to end early in 2004.

It is not surprising that these issues, while not formally on the agenda, are arising in the meetings of various Hep C-related groups that I have attended. I suspect that they will also strongly emerge from the "Stigma" discussions we will have.

In any event, both these topics do require discussion at the board level. We need to identify critical issues and set up a framework for what we would like to see emerge from the larger dialogue.

(AASLD Highlights—Continued from page 1)
with a ribarivin dose of more than 13.75 mg/kg as compared with 46% in patients receiving equal or less than 13.75 mg/kg ribavirin at EOT [end of treatment]."
Poster 296: Eva Herrmann et al.

DAILY CIFN FOR GT 1

The data showed that genotype 1 patients with a high viral load had higher sustained responses with daily consensus/induction therapy plus ribavirin than the standard treatment in the registration trials.

This may be a worthwhile alternative for such patients.
Poster 304: Stephan Kaiser et al.

TREATMENT FOR NORMAL ALT

Standard treatment is recommended for Hep C patients with elevated ALT levels, even though many persons with normal ALT levels are also infected with the virus.

This study included 491 patients with normal ALT levels, divided into 3 groups: One group received 24 weeks of standard treatment; another, 48 weeks; and the third, no treatment.

The conclusion was "The efficacy results are comparable to those obtained in previous trials in CHC patients with elevated ALT…and duration of treatment according to genotype can be recommended following established algorithms."
Poster 106: Stefan Zeuzem et al.

"NORMAL" ALT?

This study indicated that the upper limit of ALT should be far below what is recommended by the manufacturer of the test (i.e., 52). Many patients with hepatitis C have "normal" ALT levels, but treatment is often restricted to those whose levels are "elevated."

The study included 272,273 consecutive patients. It excluded those with other blood abnormalities, those being treated with drugs known to affect the liver, those overweight, those known to have liver disease, alcoholics, and so on.

17,929 patients remained in group 1. Group 2 included those with hyperlipidemia and/or diabetes with high cholesterol, triglycerides, glucose, HbA1C. Group 3 included diabetics with only high glucose and/or HbA1C.

Average ALT levels were as follows: group 1, 37 (male 45, female 31); group 2, 40; group 3, 45.
Poster 72: Revital Kariv et al.

TREATMENT OF THE ELDERLY

Little data is available on hepatitis C in patients 65 years or older .This study was done to see how severe the disease is in 4,039 patients in this group and how safe and effective treatment is.

ALT levels were lower than in younger patients. In those receiving IFN and/or ribavirin, treatment was effective and well tolerated.
Poster 549: Dominique Thabut et al.

AGE IS A FACTOR

The age of the patient has a great influence on treatment response.

"The probability of a 20-year-old patient achieving an SVR was 74.4% … The probability of a 60-year-old achieving an SVR was 44.2%." If the patient were to adhere to the treatment schedule, "the probability of achieving an SVR increased to 85.4% in the 20-year-old and 52.9% in the 60-year-old."

This study used data from 2 previous trials. All patients had genotype 1, were Caucasian, and were aged 20 to 60 years.
Poster 189: *Graham R Foster et al.*

WHEN TO STOP

Sustained viral response can be predicted at 1 or 4 weeks of treatment, independent of genotype, by new composite DITTO-1st-week or DITTO-2nd-slope prediction criteria.

The current consensus stopping rule is defined at 12 weeks of treatment with peginterferon-alfa and ribavirin.

Earlier prediction is needed in order to improve the cost/effect ratio. These results warrant larger trials.
Poster 192: Avidan U Neumann et al.

CORE AG TESTING

A new quantitative marker of HCV viral load based on the detection of the core Ag of the virus has recently become available in Europe (T*rak*-C assay–Ortho Clinical Diagnostics, Raritan, NJ).

The use of this assay, together with the proposed quantitative threshold, would have allowed for the unequivocal identification at 12 weeks of non-responders.

The core assay is a reliable alternative for the early identification of non-response.
Poster 1187: Pierre Pradat et al.

RELAPSE AFTER 5 YEARS

European sustained responders were re-examined, and it was found that the late relapse rate at five years of follow up was 10.5%. Treatment with a high total dose of interferon reduces the risk of late relapse.

Sustained virological response at 6 months after treatment is presently considered the key outcome for treatment efficacy in hepatitis C.
Poster 971: Bart J Veldt et al.

HEP C AND BONE LOSS

This study shows that chronic Hep C patients have low bone mass density and a high prevalence of osteopenia (60%). The inverse correlation found between bone mass and ALT levels suggests a relation with liver damage. Low serum IGF-I levels may be involved in bone loss.
Poster 1119: Eduardo Redondo-Cerezo et al.

CIFN FOR NON-RESPONDERS

CIFN daily dosing/induction therapy with subsequent ribavirin combination therapy shows promising response rates in previous combination therapy non-responders. Almost all patients studied were infected with genotype 1. CIFN may be an effective treatment for this difficult-to-treat patient group.

After 12 weeks of consensus interferon (CIFN) monotherapy, a primary response with undetectable serum HCV-RNA was observed in 58% in the CIFN 27/18 ug group. After 24 weeks of CIFN/ribavirin combination therapy, a negative PCR was observed in 71% of the CIFN 27/18 ug + ribavirin group. The subset of patients having reached end-of-treatment and 24-week follow-up show response rates of 59 - 66% (ETR) and 37 - 43% (SR), respectively.
Poster 248: Stephan Kaiser et al.

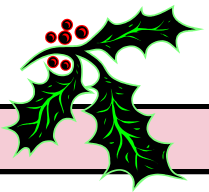
OTCAS DANGEROUS?

Over-the-counter painkillers (OTCAs) can theoretically lead to decompensation of cirrhosis. However, taking small amounts of OTCA (below recommended dosages) does not cause decompensation of cirrhosis.

Acetaminophen (e.g., Tylenol), an intrinsic hepatotoxin, might do so by damaging the liver, especially if alcohol is consumed. Non-steroidal anti-inflammatory drugs (NSAIDs) might do so by decreasing the response to diuretics and/or by promoting kidney circulation.

Alcohol is an important contributor to decompensation.
Poster 1127: Sakib K Khalid et al.

CONFERENCE SOURCE: www.hcvadvocate.org



RCMP UPDATE

RCMP Blood Task Force
Project Oleander
345 Harry Walker Parkway S.
New Market, Ontario L3Y 8P6

To whom it may concern:

RCMP Blood Task Force – Toronto North

The RCMP Blood Task Force would like to update you on the court appearances for those who were charged with criminal offences relating to the Canadian blood system.

Legal counsel for the Canadian Red Cross and Dr. Roger Perrault appeared at the Hamilton Court House on October 17, 2003. Crown attorneys have not received a direction from the Attorney General's office (Ontario) on whether to proceed by direct indictment. A decision on this matter is expected shortly. The next court date for the Canadian Red Cross and Dr. Roger Perrault is set for December 19, 2003 at 9 a.m. in Room 100, Hamilton Court House, 45 Main Street East in Hamilton, Ontario.

As a reminder, legal counsel for Dr. Roger Perrault, Dr. John Furesz, Dr. Wark Boucher, Armour Pharmaceutical Company, ad Dr. Michael Rodell will be appearing on November 10, 2003 at 9 a.m. in Court Room 111 at Old City Hall, 60 Queen Street West in Toronto, Ontario for a Case Management Conference.

The toll free line and the web site are still available for those who wish to contact the Blood Task Force.

1-888-530-1111
www.rcmp-grc.gc.ca/html/bloodtaskforce_e.htm (English)
www.rcmp-grc.gc.ca/html/bloodtaskforce_f.htm (French)

Sincerely,

D. Hvidston, Cst, BTF Liaison Officer

B.W. Fair, Insp., OIC RCMP Blood Task Force

Happy Holidays!

Happy Holidays!

HepC BC

VOLUNTEER APPLICATION FORM

NAME: _____

ADDRESS: _____
_____

CITY: _____

PC: _____ **PROV:** _____

TEL: ( ) _____

FAX: ( ) _____

EMAIL: _____

ABILITIES OR AREA OF INTEREST:

Library Printing Copying Phoning Fundraising Counseling Research Refreshments Special Events Publications Computer Help Errands Grant Applications Board Member Other

Experience:
_____
_____
_____
_____

Time available:
_____
_____

SEX M F

Date of Birth: ___/___/____

Mo Day Year

Contact: HepCBC
#5-915 Glen Vale Rd
Victoria BC V9A 6N1

Tel. 595-3892 or Email: info@hepcbc.ca

COMPENSATION

LEGAL ACTION

Hepatitis C Class Action Suit Line:
1-800-229-LEAD (5323)

1986-1990
Bruce Lemer/Grant Kovacs Norell
Vancouver, BC
Phone: 1-604-609-6699 Fax: 1-604-609-6688

Pre-86/Post-90
Hepatitis C Settlement Fund—KPMG Inc.
Claims Administrator
2000 McGill College Avenue, Suite 1900
Montreal (Quebec) H3A 3H8
1-888-840-5764 (1-888-840-kpmg)
HepatitisC@kpmg.ca
www.kpmg.ca/microsite/hepatitisc/english/forms.html

Klein Lyons
Vancouver, BC 1-604-874-7171,
1-800-468-4466, Fax 1-604-874-7180
www.kleinlyons.com/pages/class_actions/Hepatitis_C.htm

Mr. David Harvey/ Goodman & Carr
Toronto, Ontario
Phone: 1-416-595-2300, Fax: 1-416-595-0527

Ernst & Young Law Office (Ontario)
1-800-563-2387

Lauzon Belanger S.E.N.C. (Quebec)
www.lauzonbelanger.qc.ca.

Goodman and Carr LLP
pre86hepc@goodmancarr.com
www.goodmancarr.com

Other:

William Dermody/Dempster, Dermody, Riley and Buntain
Hamilton, Ontario L8N 3Z1
1-905-572-6688

LOOKBACK/TRACEBACK

The Canadian Blood Services, Vancouver, BC
1-888-332-5663 (local 207)
Lookback Programs, Canada: 1-800-668-2866
Lookback Programs, BC: 1-888-770-4800
Canadian Blood Services Lookback/Traceback & Info Line: 1-888-462-4056
Hema-Quebec Lookback/Traceback & Info Line: 1-888-666-4362
Manitoba Traceback: 1-866-357-0196

RCMP Blood Probe Task Force TIPS Hotline
1-888-530-1111 or 1-905-953-7388
Mon-Fri 7 AM-10 PM EST
345 Harry Walker Parkway, South Newmarket, Ontario L3Y 8P6 Fax: 1-905-953-7747

CLASS ACTION/COMPENSATION

National Compensation Hotline: 1-888-726-2656
Health Canada Compensation Line: 1-888-780-1111
Red Cross Compensation pre-86/ post-90 Registration: 1-888-840-5764
Ontario Compensation: 1-877-222-4977
Toronto Compensation: 1-416-327-0539, 1-877-434-0944
Quebec Red Cross Compensation: 1-888-840-5764
1986-1990 Hepatitis C Class Actions Settlement 6/15/99 www.hepc8690.ca/

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

MISCELLANEOUS

Excellent Website!!: HCV Tainted Blood, Canada: http://members.rogers.com/smking/tainted.htm

COMING UP IN BC/YUKON:

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

Campbell River Hep C Support Group Support and information, call 830-0787 or 1-877-650-8787 or email niac_hepc@hotmail.com

Castlegar Contact: Robin, 365-6137

Comox Valley: Contact North Island Hep C Community Support Project 1-877-650-8787,

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

Cranbrook HeCSC-EK: 1st & 3rd Tues. monthly, 1-3 PM, #39 13th Ave South, Lower Level. Next meetings Dec. 2nd & 16th. Contact: 426-5277 or 1-866-619-6111 hepc@cmha-ek.org, www.hepceastkootenay.com

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

Grand Forks Hep C Support Centre—Closed due to lack of funding. Contact Ken, 1-800-421-2437

Kamloops Phone support. Contact Susan, 554-7055, or the Liver Clinic, 851-7300.

Kelowna Hepkop: Last Sat. monthly, 1-3 PM, Rose Ave. Meeting Room, Kelowna General Hospital. Next Meeting: Dec. 27th. Contact Elaine Risely (250) 768-3573, eriseley@shaw.ca or Lisa Mortell 766-5132 lmortell@silk.net or toll-free 1-866-766-5132.

Kimberley Support Group 2nd Tue. monthly, 7-9 PM. Next meeting Dec. 16th Contact Katerina 426-5277

Kootenay Boundary 2nd Tues. monthly, 7 PM, Room 108, Selkirk College, Trail. Next meeting: Dec. 16th. For individual support, info & materials, contact: Brian Reinhard, (250) 364-1112, reiny57@yahoo.ca

Mid Island Hepatitis C Society Friendship and support group, 2nd Thurs. monthly, 7 PM, Central Vancouver Island Health Centre 1665 Grant St. Nanaimo. Next meeting: Dec. 11th. Contact Sue for info 245-7635. mihepc@shaw.ca

Mission Hepatitis C and Liver Disease Support Group 3rd Wed. monthly, 7 PM, Springs Restaurant, 7160 Oliver St. Next meeting Dec. 17th. 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: Dec. 16th. Contact: Vivian, 265-0073 or Ken, 1-800-421-2437

Nelson Hepatitis C Support Group 1st Thurs. monthly. ANKORS Offices, 101 Baker St., Next meeting: Dec. 4th. Contact: **Alex Sherstobitoff**, 1-800-421-2437, 505-5506, info@ankors.bc.ca

New Westminster Support Group 2nd Mon. monthly, 7-8:30 PM, First Nations' Urban Community Society, 623 Agnes Street, New Westminster. Next meeting: Dec. 8th. Contact: Dianne Morrissettie, 604-517-6120, dmorrissettie@excite.com

Parksville Support Group Contact Ria, 248-6072

Parksville/Qualicum 102a-156 Morison Avenue, PO Box 157, Parksville, BC V9P 2G4. Open daily 9 to 4, 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 Next meeting: Contact the Health Unit, 485-8850.

Prince George Hep C Support Group 2nd Tues. monthly, 7-9 PM, Prince George Regional Hospital, room 105-107 Next meeting Dec. 16th, Contact: Gina, 963-9756, gina1444@yahoo.ca or Ilse, 565-7387 ikueper@northernhealth.ca

Princeton 2nd Sat. monthly, 2 PM, Health Unit, 47 Harold St. Next meeting Dec. 13th. Contact: Brad, 295-6510. kane@nethop.net

Queen Charlotte Islands/Haida Gwaii: Phone support. Contact Wendy: 557-2487, e-mail: wmm@island.net, www.island.net/~wmm/

Quesnel HeCSC 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 Contact: Ken, 355-2732, keen@netidea.com

Smithers: Positive Living North West 2nd Wed. monthly, 12 noon, **3862 Broadway (back door)** Next meeting: Dec. 10th. Contact: Deb. 877-0042, 1-866-877-0042, or Doreen, 847-2132, plnw_hepc@bulkley.net for times.

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

Vancouver: Healing Our Spirit—Offering Hep C and HIV education and support to Aboriginal People in BC. 100 - 2425 Quebec St. Contact: 1-800 336-9726 info@healingourspirit.org www.healingourspirit.org

VANDU Vancouver Area Network of Drug Users Each Mon., 2 PM, **412 East Cordova** Bus fare & snack. Contact: Cristy or Ann, 604-719-5313, or 604-216-2776 (ask for VANDU). Space limited—come early. vandu@vcn.bc.ca, www.vandu.org

Vernon HeCSC HEPLIFE 2nd & 4th Wed. monthly, 10 AM-1 PM, The People Place, 3402-27th Ave. Next meetings Dec. 10th & 24th. Contact: Sharon, 542-3092, sggrant@telus.net

Victoria HeCSC Last Wed. monthly. Contact: 388-4311, hepcvic@coastnet.com

Victoria Support and Information Information about support groups and other services: Contact the Needle Exchange, 384-2366, hermione.jefferis@avi.org

Victoria HepCBC & INFO line —Contact: (250) 595-3892, info@hepcbc.ca, www.hepcbc.ca

YouthCO AIDS Society HepCATS Education and information to youth infected or affected with hepatitis C. #205-1104 Hornby St., Vancouver. Contact Caitlin Padgett 604-688-1441 or 1-877-YOUTHCO

Yukon Positive Lives 3rd Wed. monthly, Whitehorse. Next meeting Dec. 17th. Contact Heather 660-4808, fromme@marshlake.polarcom.com, www.positivelives.yk.ca

OTHER PROVINCES

ATLANTIC PROVINCES:

HeCSC NB Meetings:

- **Fredericton, NB** Contact: Bob, 453-1340
- **Saint John & Area**: Information and Support. Contact: Allan Kerr at kerrs@nbnet.nb.ca

Moncton. N.B. Contact Debi, email support only: hepcmonc@rogers.com

The Hepatitis Outreach Society The organization is undergoing reconstruction, for telephone support call: 1-800-521-0572 (902) 733-2214 Fax (902) 733-2043

ONTARIO:

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

Durham Hepatitis C Support Group 2nd Thurs. monthly, 7 PM, St. Mark's United Church, 201 Centre St. South, Whitby. Next meeting: Dec. 11th. Sharing time & Holiday Party. Contact: Smilin' Sandi smking@rogers.com "Sandi's Crusade Against Hepatitis C" http://members.rogers.com/smking/ or Ken Ng, (905) 723-8521 or 1 (800) 841-2729 (Ext. 2170)

Kitchener Area Chapter 3rd Wed. monthly, 7:30 PM, Cape Breton Club, 124 Sydney St. S., Kitchener. Contact: Carolyn, (519) 880-8596 lollipop@golden.net

Niagara Falls Hep C Support Group Last Thurs. monthly, 7 PM, Niagara Regional Municipal Environmental Bldg., 2201 St. David's Road, Thorold. Contact: Rhonda, (905) 295-4260, Joe (905) 682-6194 jcolangelo3@cogeco.ca or hepcnf@becon.org

Trenton ON support. Contact: Eileen Carlton 394-2924 carfam@quintenet.com

York Chapter HeCSC 3rd Wed. monthly, 7:30 PM, York Region Health Services, 4261 Hwy 7 East, B6-9, Unionville. Contact: (905) 940-1333, 1-800-461-2135. info@hepcyorkregion.org www.hepcyorkregion.org

Hepatitis C Network of Windsor & Essex County 3rd Thurs. monthly, 7 PM, 1100 University Ave. W. and 1st Mon. monthly, 491 Victoria Ave, 11 AM. Contact Andrea 250-5399 or Michelle, 256-1878, hepcnet@cogeco.ca http://home.cogeco.ca/~hepcnet/

PRAIRIE PROVINCES:

HeCSC Edmonton: Contact Jackie Neufeld: 939-3379.

HepC Edmonton Support Group: Contact Fox, 473-7600, or cell 690-4076, fox@kihewcarvings.com

HepSEE WPG: Contact David: hepsee@shaw.ca or 1(204)897-9105 for updates on meeting schedules.

Winnipeg Hepatitis C Resource Centre 1st Tues. monthly 7-9 PM. # 204-825 Sherbrook St. (south entrance—parking at rear) Contact: 975-3279, hcrc@smd.mb.ca

QUEBEC:

Hepatitis C Foundation of Quebec, Contact Eileen, 769-9040 or fhcq@qc.aibn.com. **Meetings:**

- **Hull:** Each Tue. 7-8 PM, 57 Rue Charlevoix.
- **Sherbrooke** 2nd Mon. monthly, 7-9 PM, Les Grandes Coeurs D'Artichauts Au Centre Jean-Patrice Chiasson (2e etage) 1270 Galt Street West. Contact: 820-7432
- **Verdun:** 1st Tues. (French) & 3rd Tues (Eng) monthly, 7-9 PM. Verdun General Hospital, Room 3121.

HeCSC Quebec City Region, 1st Wed monthly, 7 PM, 876 rue D'Alençon, St. Nicolas, QC. Contact: Renée Daurio, 836-2467, reneedaurio@hotmail.com