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Canada's Hepatitis C News Bulletin

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TREATMENT OF HCV INFECTION IN CURRENT AND FORMER INJECTION DRUG USERS: TIME TO CHANGE THE RULES?

Jason Grebely and Brian Conway

***Jason Grebely is** a graduate student working on HCV infection among illicit drug users at the Pender Community Health Centre in Vancouver. He has been in charge of developing a multi-disciplinary program for the treatment of HCV infection in illicit drug users.*

The spread of injection drug use (IDU) has led to an explosive epidemic of hepatitis C virus (HCV) infection in many urban populations. Of the estimated 123 million existing cases in the world, over 50% occur in IDUs, with more than 75% of new infections being associated with this risk behavior.

Pharmacologic advances have led to the development of HCV treatment regimens with improved efficacy, resulting in a "cure" in 50% of patients receiving once-weekly pegylated interferon in combination with twice daily ribavirin for 24-48 weeks, a figure that exceeds 80% (with only 24 weeks of treatment) in individuals carrying HCV genotypes 2/3. In the past, clinical guidelines had excluded IDUs from being considered for therapy unless they had been free of injection drug use for at least 6 months. This approach is still in place in many centres, despite the fact that guidelines promoted by the National Institutes of Health in 2002 advocate for broader consideration of active IDUs on an individual basis. Concerns about patient motivation and adherence, medical and psychiatric co-morbidity, re-infection due to recurrent risk behaviors and the lack of infrastructure to ensure long-term access to care have all been raised as obstacles to the initiation of HCV treatment in this population.

(Continued on page 6)

ADIOS, FREDDY FENDER 1937-2006

Freddy Fender, three-time Grammy-winner, solo artist and member of Los Super Seven and the Texas Tornados, passed away at his home in Texas on October 14, 2006, surrounded by his family. He was 69 years old and famous for his tunes "Before the Next Teardrop Falls" and "Wasted Days and Wasted Nights". He died of lung cancer, but had other health problems. He received a kidney from his daughter in 2002 and a liver transplant in 2004 because of his hepatitis C.

Sources: www.showbuzz.cbsnews.com/stories/2006/10/12/music_country/main2086420.shtml
www.torontodailynews.com/index.php/EntertainmentNews/2006101444Freddy-Fender
www.freddyfender.com

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WORLD HEPATITIS C DAY OCTOBER 1st

By Joan King

Did you know? October 1st was declared World Hepatitis C Day by the WHO (World Health Organization) in 2003. Several countries in Europe, Australia, and the East have been celebrating it as such. We here in Canada have done much to promote May 1st as Hepatitis C Day, and May as Hepatitis C month, so when I first heard this, I was not pleased. Don't they know that it's May 1st? I have since been pondering this, and I figure the more dates we have to bring awareness to our cause, the better. May 1st can certainly be National Hep C Day here in Canada, and in the US, if they choose, but that doesn't stop us from celebrating October 1st as International Hepatitis C Day, does it? I googled "Hepatitis C Day" and came up with the following partial list. This may merit some discussion:

KARACHI: "The third annual World Hepatitis Awareness Day is being observed across the globe on Sunday [October 1, 2006] and almost 600 million people worldwide are reportedly inflicted with either Hepatitis B or C, conditions which could be life threatening." *http://www.thenews.com.pk*

"In **INDIA** it is estimated that 10,900,000 people suffer from chronic Hepatitis C. With the objective of educating people about Hepatitis, October 1 has been designated as the World Hepatitis Awareness Day. Hepatitis, as has been long established, is acting like a silent killer worldwide, and hence, the significance of this day. It is imperative to make people aware of the symptoms of the disease and the precautions that need to be taken." *http://www.indiainfoline.com*

"This year Sir Bob Geldof, of the **World Health Organization** Regional Office for **EUROPE**, the European Liver Patients' Association and international patient organisa-

(Continued on page 3)

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☐"I want to volunteer. Please contact me."
☐"I want to join a support group. Please call."

(Note: The hepc.bull is mailed with no reference to hepatitis on the envelope.)

SUBMISSIONS: *The deadline for any contributions to the* **hepc.bull**© *is the 15th of each month. Please contact the editors at info@hepcbc.ca, (250) 595-3892. 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:*

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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.

NEW!!! FAQ v7

Peppermint Patti's FAQ Version 7 is now available, and Version 5.6 is available in Spanish. The English version includes updated Canadian Links and includes the latest TREATMENT INFORMATION. Place your orders now. Over 125 pages of information for only $7 each, plus postage. Contact HepCBC at (250) 595-3892 or info@hepcbc.ca

HepCBC Resource CD

The CD contains back issues of the *hepc.bull* from 1997-2005; the FAQ V6; the slide presentations developed by Alan Franciscus; and all of HepCBC's pamphlets. The Resource CD costs $10, including S&H. Please send cheque or money order to the address on the subscription/order form on this page.

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.

THANKS!!

HepCBC would like to thank the following institutions and individuals for their generosity: The late John Crooks, Bruce Lemer, Lexmark, Health Canada, Pacific Coast Net, Margison Bros Printers, Royal Bank, Schering Canada, Roche Canada, the Provincial Employees Community Services Fund, Brad Kane, Chris Foster, Judith Fry, the FitzGerald family, S. Segura, The Four Mile Restaurant, Victoria Bridge Centre, Erik, Irene, Chateau Victoria, the Victoria Symphony, the Victoria Conservatory, the Shark Club, Recollections, Thrifty Foods, Patisserie Daniel, Preview Hair Studio, and the newsletter team: Tanya, Beverly A., Diana Ludgate, Alp and Ernie. Heartfelt thanks to Blackwell Science for a subscription renewal to gastrohep.com

BE PART OF THE TEAM!

We need people to **summarize articles.** HepCBC needs **telephone buddies, a librarian** and 2 people to help with our website. The HepCan list needs a moderator trainee. Please contact Joan at 250-595-3892 or info@hepcbc.ca

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, #306-620 View Street, Victoria, BC V8W 1J6, (250) 595-3892.**

Give us your name, tel. number, 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.

Want a mate? Your Cupid ad could go here!

Got Hep C? Single? Visit:

http://forums.delphiforums.com/HepCingles/
http://groups.yahoo.com/group/PS-Hep/
http://groups.yahoo.com/group/HepCingles2
http://groups.yahoo.com/group/NewHepSingles/
CHAT: http://forums.delphiforums.com/hepatitiscen1/chat

Do you Have Hepatitis C?

You may be eligible to participate in a Research Study.
TO QUALIFY
We are looking for people who have hepatitis C and had no prior treatment with Interferon.

DETAILS:
You will be required to **take** investigational medication in combination with Peginterferon Alpha-2b and Ribavirin (Pegetron) for treatment of hepatitis C.
You will be required to **give blood samples.**
There will be 1 overnight stay with several out-patient visits.
If you qualify, compensation will be available.
For more information, please contact the **Recruitment Coordinator at 604-875-5122, extension #7 or E-mail**

PRE-PLANNING YOUR FINAL ARRANGEMENTS?

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

TANYA'S TIDBITS *by Tanya Frizzle*

WHO CARES?

It is really important for anybody going through the trials and tribulations of HCV to have supportive people around them. They may be family, friends or even a support group. I have found out that it is also important to have support from the medical system. You need to feel comfortable with the people to whom you confide all of your medical issues and know that they care.

Last week I had a concern regarding HCV and phoned my health nurse and left a message for her. I said simply that I had a question regarding HCV and when she had some free time to call me back. She called me within the hour! She answered my question and calmed some of my fears. I got off of the phone and thought about the fact that she has led me through a lot over the last year and I am very grateful to have her in my life. I know that if I have any issues, questions, concerns, or complications that I can go to my doctor's office and everybody there cares. That is just about as important as a strong support group around you—maybe even the cornerstone to the support needed.

LIVER BIOPSY NECESSARY?

I have had a liver biopsy and I will admit it is not the most comfortable procedure in the world to go through, however at the time it was important to me to have answers.

Last week, I got into a conversation with a specialist who was not my own regarding liver biopsies. He does not have them done on his patients as he sees them as pointless. He explained that liver biopsies are not always correct in their findings. He also went on to say that you should not base treatment decisions on the biopsy results because if you are in stage 1 you have better results and if you are in stage 4 you should definitely treat to prolong your life. Therefore the biopsy results are irrelevant. He has a point. I agree with what he had to say, however, things are not always so black and white.

I started treatment before I got a liver biopsy and part way through it was realized that the treatment was not working. I was given a choice: stop treatment, or try something new by switching from one treatment to the next without a break in between. I did not know what to do. It was pointed out to me that if I had had a biopsy done, it might have made my decision easier. If I was in stage 1, maybe doing something new was not worth it, but if I was in stage 4 maybe trying anything new at all might prolong my life.

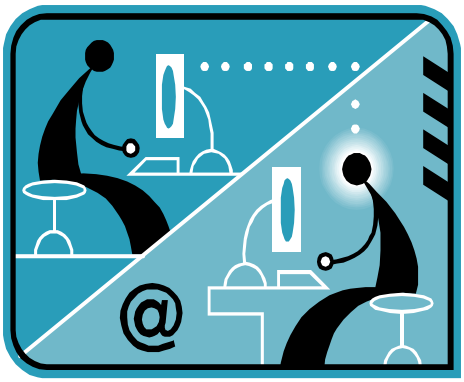
My platelets were low and therefore a biopsy could not be performed on me while I was on treatment, so I had to make this decision without knowing where I was at with HCV. It was very confusing and stressful.

I went ahead with the trial because I simply did not know the state of my health. The trial failed and a biopsy was done after. I am in stage 1 going into stage 2. Had I known this prior to treatment, would I have done the trial? Probably not.

HOW LONG TO LIVE AFTER LIVER TRANSPLANT?

A study has been performed on 2702 liver transplant patients who survived the first 6 months after transplant. Some had Hep C. Females fared the best, with a survival rate of 26 years, compared to 31 of the age-matched, non-transplanted, general population. For men it was 18 years compared to 27. There was an estimated loss of 7 years of life compared to age-matched and sex-matched controls. The younger the recipient, the better the outcome. Ages 17 to 34 had the longest expectancy of 28 years, however it was noted that people who had transplants for cancer, HCV and alcoholic liver disease had the greatest loss of life-years.

http://www.hivandhepatitis.com/hep_c/news/2006/101306_c.html



DO YOU NEED SOMEBODY TO TALK TO?

Do you need somebody to talk to but are uncomfortable going to a group meeting or session? Not comfortable in chat rooms? If you need a shoulder to cry on, a person to rant to, or somebody to understand, please feel free to e-mail me at tanyafrizzle@hotmail.com. Not only do I live with HCV and have been through failing treatment, I have also lived through my father passing away from HCV. So even if you do not have HCV and are a concerned friend or family member who has questions, feel free to contact me.

*(**WORLD HEP C DAY**—Continued from page 1)*

tions are working together to raise awareness about hepatitis B and C. The theme for this year is 'Get Tested' and people at risk from the disease are encouraged to do just that - Get Tested! Mark your calendars - 1 October 2006 is the third annual World Hepatitis Awareness Day."

en.wikipedia.org/wiki/World_Hepatitis_Awareness_Day

"The majority of the **UAE** population is unaware of Hepatitis C, a survey by Hoffmann-La Roche reveals. The survey…coincided with World Hepatitis C day on October 1 and studied a mix of 330 Emiratis, Arab and Asian expats from Abu Dhabi, Dubai and Al Ain. Only 13% of people surveyed had been tested for Hepatitis C." *http://www.middleeasthealthmag.com/cgi-bin/index.cgi?http://www.middleeasthealthmag.com/nov2005/meupdate.htm*

"The number of hepatitis C cases in **GREECE** shows a progressive increase as a result of the arrival of immigrants from the former Soviet Union…The figures on hepatitis C were made public on the occasion of Hepatitis C Day on October 1." *http://www.hri.org/news/greek/mpab/2005/05-09-29.mpab.html*

"This year, the 2006 National Hepatitis Awareness Campaign [**AUSTRALIA**] [was held] during the week of 1st - 7th October, to coincide with International Hepatitis C Day which is the 1st October." *http://www.cnet.ngo.net.au/index.php?option=com_content&task=view&id=15758*

DIAL-A-DIETITIAN

604-732-9191 (Vancouver Area)
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SULPHASALAZINE

Sulphasalazine is approved for use in cases of arthritis and inflammatory bowel disease. An English study on animals showed it to be effective in reversing liver scarring (cirrhosis). The liver has cells called myofibroblasts which create scar tissue. Sulphasalazine stops the myofibroblasts from producing scars. Researchers hope this will prove true for humans, too. The treatment costs about $20.00 a week.

Source: Christian Nordqvist http://www.medicalnewstoday.com/healthnews.php?newsid=52735, 26 Sep 2006, Sulphasalazine can reverse liver disease even for heavy drinkers

STOPPING TREATMENT

Patients may avoid the side-effects and expense of unsuccessful treatment by stopping at 4 weeks if they are still HCV-positive at that time. Right now the standard mark of success or failure are the PCR results at 12 weeks. French researchers compared data from 186 patients treated with peg-IFN + ribavirin, tested viral loads at 4, 8 and 12 weeks, and concluded that, "A Week 4 stopping rule for patients with chronic hepatitis C treated with peginterferon with ribavirin might be proposed by using the model developed in our study."

Source: http://www.hivandhepatitis.com/hep_c/news/2006/101006_c.html 4-Week Response to Anti-HCV Treatment Predicts Outcome
Reference: M Martinot-Peignoux, et al, Journal of Viral Hepatitis 13(10): 701-707. October 2006.

REPEAT STUDY RESULTS

What do we do with non-responders to previous therapy? And what about the relapsers, who should be considered separately? The question remains whether, with more sensitive tests, it may be discovered that so-called relapsers may actually be non-responders. Perhaps their virus was there all the time, but the test couldn't find it.

A large REPEAT study has begun, and interim results were released. 950 non-responders to a minimum of 12 weeks of peg-IFN alfa-2b + ribavirin were studied. Patients were given either a standard dose or fixed high-dose (360 mcg/week peg-IFN alfa-2a + weight-based ribavirin daily) for 12 weeks and then a standard-dose. Retreatment produced up to a 45% EVR with standard-dose treatment and up to a 62% EVR (end of treatment) with fixed high-dose induction. These preliminary results are encouraging, but still not enough to regularly increase doses and make treatment longer.

Source: Peter Ferenci, MD Treatment of Nonresponders: The REPEAT Study 2006 Annual Meeting of the European Association for the Study of the Liver

72 WEEKS MORE EFFECTIVE

Most patients who respond effectively to treatment test undetectable by week 4. Some doctors recommend stopping treatment in the rest of the patients, to avoid discomfort, but this Spanish study investigated prolonged treatment (72 weeks rather than 48) in 326 slow responders. Half stopped treatment at 48 weeks, and half continued for 72.

The authors concluded that 72 weeks increases the rate of sustained response in patients whose virus is still detectable at week 4 of treatment.

Reference: J M Sanchez-Tapias, et al. Peginterferon-alfa2a plus ribavirin for 48 versus 72 weeks in patients with detectable hepatitis C virus RNA at week 4 of treatment. Gastroenterology. 131(2): 451-460. August 2006.

CO-TREATMENTS

McHutchison and colleagues disclosed data from their Phase II study of eltrombopag, an oral platelet growth factor, given to patients with bleeding disorders who might have had to stop interferon therapy if their platelets dropped too low. Eltrombopag, given to patients orally during 4 weeks before HCV treatment and continuing the drug 12 weeks into treatment increased their number of platelets. All of the patients treated were able to receive full-dose therapy.

Some patients are given viramidine rather than ribavirin to reduce anemia. Filgrastim is used for patients who develop neutropenia. Eltrombopag is better than other platelet treatments because it is taken once daily by mouth, and has fewer side effects.

Source: Oral Platelet Growth Factor Eltrombopag 2006 Annual Meeting of the European Association for the Study of the Liver

SCH-503034

The combination of SCH-503034 with peginterferon alfa-2b improved antiviral activity and reduced resistance to treatment in this trial of 22 nonresponders. Because of these results, a large, phase II trial is about to begin, with more than 350 patients worldwide, to evaluate double and triple combination therapy with ribavirin. "This is exciting, since it is a major study moving forward with protease inhibitors."

Source: Nezam H. Afdhal, MD, Treatment of Nonresponders With Combination SCH-503034 Plus Peginterferon Alfa-2b2006 Annual Meeting of the European Association for the Study of the Liver

CANNABIS REVISITED

By Alp

After reading "Marijuana and Treatment" in last month's *hepc.bull,* I questioned the results.

The researchers state that cannabis (C) users showed a higher sustained virologic response (SVR) than non-cannabis (NC) users (54% vs. 18%) or 12 people in the C group vs. 9 people in the NC group. They also state that the end of treatment virological response (EVR) is higher among C users (64% vs. 47%) or 14 people in the C group vs. 23 people in the NC group. They claim a relapse rate of 14% in the C group and 61% in the NC group.

I first questioned the results and did some math. The claim that 18% of NC achieve SVR implies that 82% did not. But the researchers only report a 61% relapse rate for this group. Again with the C group, 54% achieve SVR which implies 46% did not, but they only report a 14% relapse rate for the C group.

I looked up the source of the article, http://www.natap.org/2006/HCV/091506_02.htm. After reading it over quickly, more questions came to mind and I am left with the feeling that the way the results are reported are not very convincing.

It seems that several people discontinued the treatment during this study. The researchers report 1 of the C group and 16 of the NC group stopped treatment early. Was the data modified to show this? No, not really.

The total number of people in the C group was 22. There were 49 in the NC group.

One in the C group discontinued. 16 in the NC group discontinued.
That leaves 21 people in the C group and 33 people in the NC group.

If, as the researchers state, 14 of the C group achieved EVR, then (14/21)x100 = 66.6% achieved EVR, .not the 64% reported.

Doing the same for the NC group, with 23 people achieving EVR, (23/33)x100 = 69.7%. This is quite different than the 47% reported by the researchers. The two groups are almost equal in EVR!

If we remove the people who stopped treatment early from the total number of people who were originally in each group, then the results change, and can change quite a bit!

For SVR, 12 out of the 21 remaining in the C group achieved SVR. This is 57%. In the NC group, 9 out of 33 remaining gives 27.3%. This is higher than the 18% the researchers reported.

(Continued on page 5)

(CANNABIS REVISITED—Continued from page 4)

Another factor is the number of genotype 1 patients. People with genotype 1 are harder to cure. The researchers state that 10 patients in the C group were type 1 while there were 30 in the NC group. These are totals for the people who started the study. 1 person in the C group dropped out and 16 in the NC group dropped out. How many who remain were genotype 1?

This may impact the way we see the data, as genotype 1 is harder to cure. If the NC group ended up with a higher percentage of genotype 1 than the C group, SVR % rates are expected to be lower in the NC group.

Reading through the article, I found new information.

1) All the subjects were on methadone treatment for addiction to opiates.
2) 35% of the subjects used other street drugs (amphetamines, cocaine, opiates) while in the study.
3) The number of genotype 1 in each group after the dropouts left was not reported.
4) The way the percentages were done skews the results to make the C group look better.
5) As the two groups were made up of patients with a history of intravenous drug use, how many of them might have other illnesses such as HIV that might lower response to HCV treatment?

It would seem that there is some evidence that the C group did better than the NC group but the article raises more questions than they answer. It must also be pointed out that the study group, all being on methadone treatment, represents a small portion of the population of people with HCV and that this specific subgroup will have issues with HCV treatment that others in different lifestyles do not share. To conclude that cannabis will help people outside this subgroup would be incorrect based on the given data.

Hepatitis C COUNCIL of British Columbia

CONFERENCE PROGRAM
Coast Hotel / Kelowna, BC
November 17 – 19, 2007

Friday November 17th – Council Business

8:00am–9:00am Breakfast
9:00am–9:30am Welcome and introductions
9:30am–10:00am Update, tasks completed
10:00am–10:45am Regional discussion and updates, summaries for report
10:45am–11:00am Break
11:00am–12:00pm Preparation of summaries for report back to large group
12:00pm–1:00pm Lunch
1:00pm–1:30pm Working Group elections
1:30pm–2:00pm Presentation: Expert Patient Program–update, next steps
2:00pm–2:30pm Discussion: Hepatitis C Awareness Week
2:30pm–2:45pm Break
2:45pm–3:45pm Discussion continued

Saturday November 18th - Skills Building

8:00am–9:00am Breakfast
9:00am–10:30am Presentation: Influencing policy makers (presenters TBD)
10:30am–10:45am Break
10:45am–12:15pm Proposal Writing, panel and workshop (Marcie Summers)
12:15pm–1:15pm Lunch
1:15pm–2:00pm Presentation: Living Wills
2:00pm–2:45pm Presentation: End stage Liver disease, patient and physician panel
2:45pm–3:00pm Break
3:00pm–4:00pm Presentation: Changes to reporting functions (PHAC)
4:00pm–7:00pm Break
7:00pm–10:00pm Dinner and presentation – New HCV drugs

Sunday November 18th–Council Business

8:00am–9:00am Breakfast
9:00am–9:30am Presentation: Viral Hepatitis Strategic Framework--Stephen Smith
9:30am–11:00am Discussion: Setting priorities for the coming year, next steps, etc
11:00am–11:15am Break
11:15am–12:30pm Discussion: Setting priorities (Continued)
12:30pm–1:30pm Lunch, departure
1:30pm–2:30pm Working group meeting

http://www.bchepcouncil.ca/
250-883-3118

PegCARE

PegCARE is a reimbursement program to help people who don't have third party coverage pay for their Pharmacare deductible for hepatitis C treatment. It is pro-rated, so the less someone's net family income is, the more help they get. Basically, if someone's net family income is less that $30,000, they will get 100% reimbursement. The more they make, the less of a percent is reimbursed, up to a max of $100,000 income.

The patients must be signed up for Fair Pharmacare to qualify, and they also need to provide a copy of their last year's T4 form to show income level.

Each treating physician and hepatitis support nurse has these forms available to them. There is a toll free number that can be called if there are any questions or if help is needed. It's only a single page, a simple form to fill out.

PegCARE: 1-800-603-2754

PEGASSIST

The PegAssist Reimbursement Assistance Program provides reimbursement coordination assistance for patients who have been prescribed Pegasys or Pegasys RBV. The program will assist in securing funding for patients to ensure that they can start, stay on, and complete their treatment successfully.

PegAssist Reimbursement Specialists are available (Monday to Friday, 10 AM- 6 PM EST) by calling: 1-877-PEGASYS or 1-877-734-2797. Patients can also obtain a program enrollment form from their nurse/physician to gain access to the program.

The program provides financial aid to qualified patients, alleviating any financial barriers which may prevent patients from starting treatment, i.e., deductibles and/or co-payments.

In partnership with CALEA Pharmacy, the program can conveniently deliver the medication directly to patients' homes or to the clinics.

COMPETITION!

HepCBC is looking for writers for the next issue of the *hepc.bull*, and is willing to pay $50.00 for a featured article. The article should be original, consist of 500 to 800 words, and of course, be about hepatitis C. It may be, for example, about the author's experience with hepatitis C, a study (with references) on some aspect of the disease, or a call for action. Submissions should be in by the 15th of next month, ***stating interest in the bonus.*** If there is more than one submission chosen, the editors reserve the right to print both, or leave one for a future edition. info@hepcbc.ca

VX-950 COMBO

The combination of VX-950 and peg-IFN alfa-2a was used by Reesink and colleagues in a 14-day trial of 20 genotype 1 treatment-naive patients who received either VX-950 (given every 8 hours) plus peg-IFN alfa-2a on days 1 and 8; VX-950 alone; or peg-IFN alfa-2a alone on days 1 and 8.

In patients receiving VX-950 plus peg interferon alfa-2a, 4 out of 8 became undetectable. There was an average 5.5 log reduction in the viral load after 14 days. In the monotherapy VX-950 arm, 1 of 8 patients became undetectable. No patients in the interferon monotherapy arm became undetectable. Hopefully the combination of VX-950 and peg-IFN alfa-2a with ribavirin will be studied further.

Source: 2006 Annual Meeting of the European Association for the Study of the Liver Peter Ferenci, MD

VALOPICITABINE

In a Phase IIb trial, Afdhal and colleagues found that valopicitabine (an HCV polymerase inhibitor) plus peg-IFN alfa-2a was more effective in genotype 1 nonresponders than retreatment with peg-IFN alfa-2a plus ribavirin. There were cases of vomiting, especially with the higher, more effective dose of valopicitabine. Sustained clearance of the virus is still unclear. The drug may be more effective at a lower dose, combined with other antivirals, or perhaps anti-nausea drugs can be used. Vomiting is also experienced in 3% of people on standard treatment.

In a Phase IIb trial of 173 treatment-naive genotype 1 patients headed by Dieterich, valopicitabine plus peginterferon alfa-2a was compared to peginterferon alfa-2a plus ribavirin. The combination of valopicitabine and peginterferon alfa-2a showed 80% of patients achieving an early virologic response with 65% undetectable at week 12.

Source: Stephanos J. Hadziyannis, MD:2006 Annual Meeting of the European Association for the Study of the Liver HCV Polymerase Inhibitor Valopicitabine.

R1626

R1626, an HCV polymerase inhibitor in early development was given to 23 treatment-naive patients infected with genotype 1 patients. The trial consisted of two different doses and a placebo arm. R1626 was well tolerated and ALT and viral levels were lowered. Unfortunately, the viral load tended to increase by day four. Hopefully more trials will be done with longer treatment and in combination with other products in double and triple therapy.

Source: Stephanos J. Hadziyannis, MD: HCV Polymerase Inhibitor R1626, 2006 Annual Meeting of the European Association for the Study of the Liver

ChronVac-C

ChronVac-C® is a therapeutic vaccine which is a kind given to those already infected with a disease, to help their immune systems. ChronVac-C® is also a "genetic vaccine", since the vaccine's genetic code is used. The vaccine DNA is designed to be injected into muscle, where it is absorbed, and the DNA is converted into protein to make the body create an immune response. To avoid the problem of the DNA remaining outside the muscle cells, the doctor would apply two electrical pulses from the InovioTM's Medpulser device, which temporarily opens the pores of the cell membranes so that the DNA can enter. This method has been demonstrated to be effective in mice. A phase I trail in healthy volunteers will start late this year.

Source: ChronVac-C®: an Entirely Novel Treatment for Chronic HCV (Hepatitis C Virus) Infections http://www.tripepeng.webbinfo.nu/page/%7B49D4019B-6784-4C05-AA1D-F221DD8FF03D%7D.htm

NOV-205

A Phase 1b clinical trial has begun. It involves Novelos Therapeutics' Hep C drug NOV-205, and it will be given as monotherapy to 30 genotype 1 non-responders to peg-IFN + ribavirin. There will be a placebo arm to the trial. NOV-205 is thought to protect the liver, change the immune system, and act as an anti-inflammatory agent. It has been approved in Russia, since it was shown to reduce or eliminate viral levels and improve liver tests. It is well tolerated and inexpensive. Results are expected in the first half of 2007.

Source: BUSINESS WIRE Sept. 28, 2006Novelos Therapeutics Enrolls 1st Patient in Hepatitis C Trial with NOV-205 (See www.novelos.com on the `Clinical Trials' page.)

HCV-796

Data was presented from a Phase Ib monotherapy study of HCV-796 at the Digestive Disease Week 2006 conference last May. This polymerase inhibitor was developed by ViroPharma and Wyeth, and is also a part of a combo study with peg-IFN. A Phase II trail is being planned.

Source: http://www.hivandhepatitis.com/2006icr/

(TREATMENT OF IVUs—Continued from page 1)

Preliminary reports from some centres have confirmed that many IDUs may be likely to consider treatment if this is coupled with a comprehensive approach to their medical and psychiatric needs (including a systematic addiction treatment program) within existing infrastructures. How do we move forward from these positive, anecdotal reports to a more systematic approach to meet the needs of the millions of IDUs living with this condition, not to mention the hundreds of thousands that will become infected in the next year?

The first simple measure is to raise awareness in the affected population. A recent study has demonstrated that as many as 80% of infected IDUs would be motivated to receive treatment if it were made available to them. This desire may well extend to a broader population of IDUs of unknown HCV status, who upon being informed of the availability of potentially curative treatment, would come forward to be tested. In fact, in our own centre we were able to determine that 64% of our population was infected with HCV and that 45% of these carried genotype 2 or 3 infection. This was a pleasant surprise, as it indicates that a significant minority of our patient population could receive a 24-week course of treatment with a high expected cure rate. We think this information will help us engage even larger numbers of individuals in care. Our results should also provide the impetus for other centres to conduct systematic surveys of their patient populations to help plan for the implementation of treatment programs.

The second measure is to develop pilot programs for the treatment of HCV in selected individuals, in a way that will maximize the likelihood of success and allow us to identify the criteria necessary for their scale-up. At our centre (the Pender Community Health Centre), HCV-infected IDUs who were viremic, non-cirrhotic, with ALT levels over 1.5x ULN and in whom there was a reasonable expectation of adherence to therapy were offered 24-48 weeks (based on HCV genotype) of combination therapy with ribavirin along with interferon-a2b (IFN-a2b) replaced by PEG- interferon-a2b (PEG-IFN-a2b) as it became available. Staff administered all injections under direct observation. In total, 40 patients received therapy with IFN-a2b (12) or PEG-IFN-a2b (28), 55% with genotype 2 or 3 infection. In total, 35% reported illicit drug use in the past 6 months. Overall the rate of sustained virologic response was 55%, 64% in subjects

(Continued on page 7)

(TREATMENT OF IVUs—*Continued from page 6*)
with genotype 2/3 infection. Pretreatment drug abstinence and illicit drug use during treatment did not have a significant impact on response rates, as long as interventions were available to prevent the drug use from becoming regular. It is quite encouraging to see that a number of pilot studies in Australia, Europe and the United States have already generated results similar to our own. The key will be to systematically identify which components of the program will be needed to ensure its success, a concept that will likely vary according to the centre and its specific population.

Finally, it will be important that these programs be implemented within research protocols, to ensure their rigorous design and evaluation. An important concern remains the risk of re-infection with HCV after treatment. If this were high, it could rapidly negate the benefit of any therapeutic interventions. We have already begun to compare the incidence of HCV infection in those having spontaneously cleared their viremia to those who were documented to be previously uninfected. HCV re-infection was documented in 14/152 (9.2%) individuals or an incidence rate of 1.8 cases/100 person-years. In contrast, new infections were documented in 172/926 (18.6%) individuals, at a much higher rate of 8.1 cases/100 person-years. These data are consistent with those generated in a cohort of IDUs in Baltimore. Although we have not yet identified the mechanism of the protective effect of prior infection, we will be able to design studies to establish this as well as to see if the reduced rate of re-infection extends to those who have cleared infection while on treatment as compared to those with spontaneous clearance of viremia. In the meantime, these data reassure us that we should continue to develop our treatment programs while these questions are being addressed.

As IDUs constitute the bulk of the HCV epidemic in developed countries, it is quite clear that any comprehensive approach to control this epidemic must include a systematic strategy to address this group. The development of such programs may be quite complex, but the ultimate benefit (for the treated population and for society as a whole) is certainly worth the effort.

TIP OF THE MONTH:

DON'T FORGET YOUR FLU SHOT!

RESEARCH

GENE-SHUFFLED IFN BETTER

A study by Brideau-Andersen and colleagues evaluated some IFN alfa genes created with a gene-shuffling technology. Fifteen of the genes were determined to have better antiviral activity than interferon alfa-2a and consensus interferon. One even had ten times more immunostimulatory activity than consensus interferon in a test tube. It is thought that these agents may improve treatment results, compared to those used with standard treatment. They are now being pegylated. Interferons may be needed to bolster the new antivirals.

Source: 2006 Annual Meeting of the European Association for the Study of the Liver Gene-Shuffled Interferon Alfa for the Treatment of HCV Infection, Nezam H. Afdhal, MD and Peter Ferenci, MD

RITONAVIR + PROTEASE INHIBITORS

Ritonavir, an antiviral used in HIV treatment, is a good booster for the protease inhibitors. It can maintain the levels of the drugs in the body, reducing the doses needed, and hopefully improving adherence and preventing resistance of the virus. The protease inhibitor VX-950 was well tolerated among HCV-infected patients. It produced the best viral response for any single HCV drug to date. VX-950 and SCH-50304 were found to be metabolized within 30 minutes, but by adding ritonavir, the metabolism of both was inhibited by over 98%. The combo is being tested in animal models with excellent results so far. Ritonavir may allow the other drugs to be taken less frequently, thus making treatment compliance more feasible.

Source: Nezam H. Afdhal, MD and Peter Ferenci, MD http://clinicaloptions.com/Hepatitis/Conference%20Coverage/Vienna%202006/Tracks/HCV/HCV%20Therapy/Pages/Page%202.aspx

COMPENSATION LINKS

Many thanks to Wendy, who sent these links *(http://www.wendyswellness.ca/links.htm)*!

1 - Pre-86 Hep C Compensation Update for people infected through the Canadian blood system before 1986 or after 1990. *http://hepccc.blogspot.com/*

2 - The Hepatitis C Compensation Coalition promotes fair and equal compensation for Canadians infected through the blood supply. *http://www.hepccc.ca/*

3 - Tainted Blood Trials and Proceedings related to the tainted blood tragedy in Canada *http://ca.groups.yahoo.com/group/TaintedBlood-TrialsandProceedings/*

COMPENSATION

LAW FIRMS

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

Pre-1986/ Post-1990

Klein Lyons
Vancouver, BC 1-604-874-7171,
1-800-468-4466, Fax 1-604-874-7180
www.kleinlyons.com/hepc/intro.html

David Harvey
Toronto, ON
Phone 416-362-1989; Fax 416-362-6204

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

Roy Elliot
Roy Elliott Kim O'Connor LLP.
hepc@reko.ca www.reko.ca

Kolthammer Batchelor & Laidlaw LLP
#208, 11062 – 156 Street,
Edmonton, AB T5P-4M8
Tel: 780-489-5003 Fax: 780-486-2107
kkoltham@telusplanet.net

Other:

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

LOOKBACK/TRACEBACK

The Canadian Blood Services, Vancouver, BC
1-888-332-5663 (local 3467) or 604-707-3467
Lookback Programs, Canada: 1-800-668-2866
Look back 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, ON L3Y 8P6 Fax: 1-905-953-7747

CLASS ACTION/COMPENSATION

Class Action Suit Hotline: 1-800-229-5323 ext. 8296
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
Quebec Compensation: 1-888-840-5764
ca/en/ms/hepatitisc/forms.html

ADMINISTRATOR

1986-1990
To receive a compensation claims form package, please call the Administrator at 1-877- 434-0944.
www.hepc8690.com info@hepc8690.com
http://www.hepc8690.ca/PDFs/initialClaims/tran5-e.pdf

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
http://www.kpmg.ca

COMING UP IN BC/YUKON:

Armstrong Hepatitis C United Resource Exchange Contact: 1-888-HepCURE amberose@sunwave.net www.hepcure.ca

AIDS Vancouver Island HCV support
- **Campbell River**: Drop in, harm reduction, support, education. Contact: 250-830-0787, jeanette.reinhardt@avi.org leanne.cunningham@avi.org
- **Comox Valley** 355 6th St. Courtenay; Contact Phyllis 250-338-7400 phyllis.wood@avi.org Drop in, harm reduction, support, education.
- **Nanaimo** Each Wed 2-4 PM #201-55 Victoria Rd. Contact Anita 250-753-2437 anita.mcleod@avi.org ,
- **Port Hardy** (Sayward, Port McNeil, Alert Bay, Sointula and Woss) 7070 Shorcliffe Ave, Contact Shane, 250-926-3293 shane.thomas@avi.org. Education, mobile harm reduction, and support.
- **Victoria** 1601 Blanshard St., 250-384-2366 info@avi.org Harm Reduction.

Boundary HCV Support and Education. Support, education, presentations. Contact Ken 250-442-1280 ksthomson@direct.ca

Castlegar Contact Robin 250-365-6137 eor@shaw.ca

Cowichan Valley Hepatitis C Support Contact Leah 250-748-3432

Cranbrook HeCSC-EK Phone support. Contact Leslie 250-426-6078, ldlong@shaw.ca

Kamloops AIDS Society of Kamloops (ASK) 433 Tranquille Rd. Office 250-376-7558 Support/ Referral. ask@telus.net 1-800-661-7541 www.aidskamloops.bc.ca

Kelowna Hepkop: Last Sat. monthly, 1-3 PM, Sep-May, Rose Ave. Meeting Room, Kelowna General Hospital. Contact Elaine 250-768-3573, eriseley@shaw.ca, Lisa ljmortell@cablelan.net or 1-866-637-5144.

Kootenay Boundary: Individual support & info Contact Brian Reinhard 250-364-1112 reiny57@yahoo.ca

Mid Island Hepatitis C Society 2nd Thurs. monthly, 7 PM, Central Vancouver Island Health Centre 1665 Grant St. Nanaimo. Contact Cindy 250-756-4771 midislandhepc@hotmail.com

Nakusp Support Contact. Contact Vivian 250-265-0073 Claire@columbiacable.net

Nelson Hepatitis C Support Group 1st Thurs. monthly 7-8:30 PM. ANKORS Offices, 101 Baker St. Drop-in library M-Th 9-4:30. Contact Alex 1-800-421-2437, 250-505-5506, info@ankors.bc.ca alex@ankors.bc.ca www.ankors.bc.ca/

Mt Waddington Harm Reduction Each Tues. 10-12 8635 Granville, Pt. Hardy. Contact Dan 250-902-2238 mtwreduc@hotmail.com

New Westminster Support Contact Dianne Morrissettie, 604-525-3790 before 9 PM. dmorrissettie@excite.com

Pender Harbour Hep C Support & Info Contact Myrtle Winchester 604-883-9911 or 604-883-0010 myrwin@telus.net

Powell River Hep C Support Group Powell River Community Health, 3rd Floor–5000 Joyce Ave. Contact: 604-485-3310

Prince George Hep C Support Group 2nd Tues. monthly, 7-9 PM, Prince George Regional Hospital, Rm. 421. Contact Gina 250-963-9756, Ilse 250-565-7387 ilse.kuepper@northernhealth.ca

Prince Rupert Hepatitis C Support Public Health Unit 250-624-7480

Princeton Contact the Health Unit (Princeton General Hospital) or Brad at 250-295-6510 CitizenKane@hepcan.ca

Queen Charlotte Islands/Haida Gwaii & Northern BC support. Contact Wendy 250-557-2487, 1-888-557-2487, wendy@wendyswellness.ca www.wendyswellness.ca Northern BC discussion & info: http://groups.yahoo.com/group/Network-NW/

Slocan Valley Support Group Contact Ken 250-355-2732, ken.forsythe@gmail.com

Smithers: Positive Living North West Contact 1-866-877-0042 or Doreen 250-847-2132, deb@plnw.org

Sunshine Coast-Sechelt Healthy Livers Support Group Information/resources, contact Catriona, 604-886-5613 catriona.hardwick@vch.ca or Brent, 604-740-9042 brent.fitzsimmons@cgh.bc.ca

VANDU The Vancouver Area Network of Drug Users: Satellite Hep C group at Health Contact Centre (HCC), 166 E. Hastings, each Thurs. 2 PM. Bus fare & snack provided. Contact VANDU 604-683-6061; Fax 604-683-6199 vandu@vandu.org www.vandu.org

Vancouver: Pre/post liver transplant support Contact Gordon Kerr sd.gk@shaw.ca

Vancouver Hepatitis C Support Group 2nd Thurs. monthly 7-9 PM, 1141 Main St. near Sky Train -Terminal & Main, and 3rd Wed. monthly, 7-9 PM VGH, Lauener Room, LP2809, near Sassafras Cafe, Jim Pattison Pavilion, South. Contact Robert, CLF: 1-800-856-7266, 778-898-7211, radmin@liver.ca www.liver.ca

YouthCO AIDS Society HepCATS #205-1104 Hornby St., Vancouver 604-688-1441 or 1-877-YOUTHCO www.youthco.org Program Coordinator: Stephanie Grant stephanieg@youthco.org Support Program Coordinator: Brandy Svendson brandys@youthco.org

Vernon HeCSC HEPLIFE 2nd & 4th Wed. monthly, 10 AM-1 PM, The People Place, 3402-27th Ave. Contact 250-542-3092, hecsc@hepc.vernon.bc.ca http://www.hepc.vernon.bc.ca/

Victoria HepCBC Drop-in Office/Library, 306-620 View St. Phone support, interviews, info sessions. Contact 250-595-3892 info@hepcbc.ca, www.hepcbc.ca

Blood Ties Four Directions Whitehorse, Yukon Contact: 867-633-2437 bloodties@klondiker.com

If you have a Canadian HCV support group to list here, please send details to info@hepcbc.ca Please inform us of any changes by the 15th of the month —*Joan*

OTHER PROVINCES:

ONTARIO:

Barrie Hepatitis Support Contact: Jeanie for information/ appointment hepcsupportbarrie@rogers.com

Durham Hepatitis C Support Group 2nd Thurs. monthly, 7-9 PM, St. Mark's United Church, 201 Centre St. South, Whitby. **Nov. 9:** Stephanie Ruiter, RN (EC), UHN, Liver Transplant Program. Dec.: No meeting. Contacts: Smilin' Sandi http://creativeintensity.com/smking/ 1-800-841-2729

Hamilton Hepatitis C Network Support Group 4th Thur. monthly 6:-7:45 PM. **NOTE: Sept. meeting is on Tues., Sept. 26th.** Hamilton Urban Core Community Health Centre—Ask reception for the room. Contact Shannon Lane 905-522-1148 ext 312. hepc@sprc.hamilton.on.ca hamiltonhepc.net

Hepatitis C Network of Windsor & Essex County Last Thurs. monthly, 7 PM, 1078 Goyeau Street (across from Hotel Deiu Hospital). Contact 519-967-0490, amonkman@hepcnetwork.net, www.hepcnetwork.net

Kingston Hep C Info HIV/AIDS Regional Service. Contact 613-545-3698, hars@kingston.net, www.hars.ca.

Kitchener Area Chapter 3rd Wed. monthly, 7:30 PM, Zehrs Community Room, Laurentian Power Centre, 750 Ottawa St. S., Kitchener. Contact: Bob 519-886-5706 bc.cats-sens@rogers.com or Mavis (519) 743-1922 elroym222@rogers.com

Niagara Falls Hep C Support Group Contact Rhonda 905-295-4260, hepcnf@becon.org

Owen Sound — Nov. 14th: Peer support. Contact Debby Minielly, 1-800-263-3456, 376-9420, Ext. 257, www.publichealthgreybruce.on.ca/ dminielly@publichealthgreybruce.on.ca

Peel Region (Brampton Mississauga, Caledon) Contact 905-799-7700 healthlinepeel@peelregion.ca

St. Catharines Contact Joe 905-682-6194 jcolangelo3@cogeco.ca

Sudbury Circle C Support Group 1st & 3rd Thurs. Contact Nancy 705-983-4396, Cathy 705-522-3352 or Ernie hepc.support@persona.ca 705-522-5156

Toronto CLF 1st Mon monthly 7:30 PM, North York Civic Centre, 5100 Yonge Street, Committee Rm #2. Contact Gina 416-491-3353 glipton@liver.ca

Unified Networkers of Drug Users Nationally undun@sympatico.ca

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

QUEBEC:

Quebec City Region Contact Renée Daurio 418-836-2307 reneedaurio@hotmail.com

ATLANTIC PROVINCES:

Saint John & Area: Information and Support. Contact Allan Kerr 506-633-4817 kerrs@nbnet.nb.ca

Cape Breton Island, N.S. The Hepatitis Outreach Society Support Group 2nd Tues. monthly 150 Bentinck Street, Sydney, N.S. 7-9 PM. Call Cindy Coles 1-800-521-0572, 902-733-2486 Fax: 902-733-2487 hoscb@ns.aliantzinc.ca

PRAIRIE PROVINCES:

Regina, Saskatchewan Contact Doug 306-545-1628 hep-c.regina@accesscomm.ca http://nonprofits.accesscomm.ca/hep-c.regina/

HeCSC Edmonton Contact Jackie Neufeld 780-939-3379.

Hep C Edmonton HCV, pre/post liver transplant support Contact Fox 780-473-7600, or cell 690-4076

Wood Buffalo HIV & AIDS Society #002-9908 Franklin Ave, Fort McMurray, AB Contact 780-743-9200 wbhas@telus.net ww.wbhas.ca

Manitoba Hepatitis C Support Community Inc. Meets every Tues.7:00 PM, United Church Crossways-in-Common, 222 Furby Street, side door, corner of Furby and Broadway, Main Floor - look for the signs) Contact Kirk: 204-772-8925 info@mbhepc.org www.mbhepc.org

Medicine Hat, AB Hep C Support Group 1st & 3rd Wed. monthly, 6:30 PM, HIV/AIDS Network of S.E. AB Association, 550 Allowance Ave. Contact 403-527-7099 bettyc2@hivnetwork.ca

Victoria & Area S.O.L.I.D.
Society of Living Intravenous Drug Users, Consumers Support Group
Wednesdays (except welfare week) 7-9 PM
1947 Cook St, Health Unit (Cook and Pembroke)
Past and Current IDU's welcome, support, info, & referrals
Contact: momma@vcn.bc.ca