

2006 in Review



Alan Franciscus, Editor-in-Chief

Every year the information we learn about hepatitis C grows by leaps and bounds. This year is no exception – there has been more discovered about the hepatitis C virus than in any prior year. We have also been able to expand our knowledge on disease progression, new drugs in development, public awareness, policy and advocacy efforts. The review below recaps what our staff and fellow advocates have found to be some of the most important news items in 2006.

INVESTIGATIONAL HCV DRUGS:

The top newsmaker in new HCV drugs in development is Vertex's HCV protease inhibitor **Telaprevir (VX-950)**. Phase II studies of 12 patients who took telaprevir qh8 (every 8 hours by mouth) with Pegasys/ribavirin found a 99.9% reduction in HCV RNA (viral load). To date 9 of 12 patients remain HCV negative, two patients had detected HCV RNA that is believed to be related to Pegasys/ribavirin response, and one was lost to follow-up. Based on the positive study results of the study, Vertex announced the initiation of two large multi-international clinical trials that began recruitment in June 2006. Preliminary results (74 patients who received 12 weeks of telaprevir) were released in December 2006 from a larger trial of

HCV genotype 1 treatment-naïve patients. In this group it was found that 88 percent had undetectable HCV RNA. Idenix's polymerase inhibitor **Valopicitabine (NM283)** was another strong contender in 2006 that started off the year with news that the 800 mg dose of NM283 produced some serious gastrointestinal side effects, prompting a revision in the clinical trial protocol. The good news is that data released later in the year found that the 200 mg and 400 mg doses were as effective as the higher dose of 800 mg in combination with Pegasys, but without the serious side effects. Schering's protease inhibitor **SCH503034** continues to advance in clinical trial development with the initiation of a larger phase II clinical trial with Peg-Intron, with and without ribavirin. Roche also jumped into the competition of investigational new direct antiviral therapy with 2 new polymerase inhibitors – **R1626** (entering phase II studies), and **R7128** (entering phase I studies in early 2007 in collaboration with Pharmasset). Roche is also collaborating with InterMune on their protease inhibitor **ITM-191**, which is slated to begin a phase I clinical trial in early 2007. Human Genome Sciences' **Albupheron** (a form of time-release interferon) has also begun a large



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phase III study in combination with ribavirin. The study will look at dosing Albupheron once every 2 or 4 weeks in combination with daily ribavirin vs. once weekly pegylated interferon plus daily ribavirin. In 2006 there were over 30 experimental HCV drugs in human clinical testing. For the latest information about new drugs visit our HCV Drug Pipeline web page.

HIV/HCV COINFECTION:

Treatment of HCV in someone who is also infected with HIV is more urgent due to faster liver disease progression than in someone infected with HCV alone. Prior studies have found that the effectiveness of pegylated interferon plus ribavirin in treating HCV genotype 1 is lower in someone with HIV/HCV coinfection than in someone with HCV alone. The lower response rates were attributed to prior studies that used pegylated interferon in combination with

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ribavirin at a fixed dose (800 mg/day) rather than at the standard of care dose for HCV mono-infection (1000/1200 mg/day). Results from Roche's **PRESCO** clinical trial, the largest study of HIV/HCV coinfecting patients receiving Pegasys plus weight-based ribavirin (1,000/1,200 mg/day), were released and the sustained virological response (SVR) rates were 35.6% (genotype 1), 32.6% (genotype 4), and 72.4% (genotype 2 and 3). PRESCO also included an arm that extended therapy to 72 weeks for genotype 1 and 4 patients and 48 weeks for genotype 2 and 3 patients. Extended duration SVR results for the genotype 1 and 4 group was 53% in the 72 week group compared to 31% in the 48 week group. In the genotype 2 and 3 group, 48 weeks of treatment resulted in an 82% SVR rate compared to a 67% SVR in the group that was treated for 24 weeks. This is a good example of how we are now individualizing treatment and thinking outside the box. In January 2006 Schering-Plough announced the commencement of a clinical study (**ENDURE**) to test low dose PEG-Intron in cirrhotic HIV/HCV coinfecting people to help prevent or delay HCV disease progression.

FDA HCV ANTIVIRAL MEETING:

In October 2006, the Food and Drug Administration (FDA) held a meeting to discuss guidelines for the development of new investigational therapies to treat hepatitis C. While the guidelines have not been officially completed, the committee recommended (1) that clinical trials should be conducted using multiple experimental drugs such as protease and polymerase inhibitors, (2)

long term follow-up beyond the current SVR 24 week post treatment end-point, (3) preliminary data on safety and effectiveness of new antivirals in people coinfecting with HIV and hepatitis C, people with cirrhosis and pediatric patients, and (4) encouraged the study of new antivirals on liver transplant patients. The committee also wanted adequate data on African-Americans prior to marketing approval for any new HCV drugs. The meeting in October was the first in a series of FDA meetings that will help guide the clinical development of new HCV antivirals.

AWARENESS:

Steve Tyler of Aerosmith broke his silence about having hepatitis C in September 2006. Tyler also went on to announce on Access Hollywood that he was completing his 12-month treatment, and stated that the virus was "nonexistent in my bloodstream as we speak." Another celebrity in the news who started talking publicly about his battle with hepatitis C is **Christopher Kennedy Lawford**. Lawford, an actor and writer, is the nephew of John and Robert Kennedy. Mr. Lawford also wrote a memoir detailing his lifelong battle with drug and alcohol addiction titled "Symptoms of Withdrawal."

A notable awareness event was the 3rd Annual **HepCAware Telethon** produced by Hep C Aware. The HepCAware Telethon is the signature event of the partnership between Hep C Aware (www.hepcaware.org), and The Hepatitis C Caring Ambassadors Program (www.hepcchallenge.org), both non-profit organizations dedicated to raising awareness of hepatitis C. Many other Hep C organizations including The Hepatitis C Support Project jumped on board to help. The telethon was held in October

2006 and was broadcast live in the Southern California area on Los Angeles' KVMD TV for 8 hours of the event, bringing hepatitis C awareness to millions of Californians. It was also simultaneously streamed live on the internet, bringing awareness to the entire world. The show featured music performances by over 25 artists (including Dig Jelly, Ernie Payne, Scott Detweiler and Kelly's Lot), comedians, medical experts, Hep C advocates, as well as many special guests. If you didn't get a chance to see the "live" version you can check it out at www.alternative.nu. Don't forget to mark your calendar for next year's HepCAware Telethon.

ELIMINATE HEPATITIS – A CALL TO ACTION:

The National Viral Hepatitis Roundtable issued an action plan with the goal of eliminating vaccine preventable viral hepatitis, building on strategies to counsel, test and refer persons at risk for viral hepatitis, caring for those with chronic hepatitis and helping them participate in the management of their condition.

HEPATITIS B:

In October 2006, Indinix's **telbivudine** (brand name Tyzeka) was approved by the Food and Drug Administration for the treatment of hepatitis B. There are now 4 antivirals to treat hepatitis B. The other big news is that since treatment with **lamivudine** (brand name Epivir HB) and to a lesser degree **adefovir** (brand name Hepsera) leads to drug resistance some experts are recommending that other antivirals such as **entecavir** (brand name Baraclude) and **telbivudine** serve as the first-line of therapy. **Tenofovir** (an antiviral drug used to treat

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HealthWise:

The Power of Language



Lucinda K. Porter, RN

January is often a time of renewal and commitment. Although we can make a fresh start anytime of the year, there is something inviting about a new calendar. Combine this with the extra pounds put on during the holidays and the phrase *New Year's resolution* springs to mind.

Resolutions are easy. Following them is an entirely different matter. Humans are creatures of habit. Change is hard. In order to make a successful change, it is essential to make an honest and thorough assessment. Some aspects of our lives are easy to identify. For instance, we know when we are overweight or eat poorly. If we are not exercising, we know better. We know that smoking is not good for us.

However, some potentially self-destructive aspects are subtle. In particular, how we perceive our bodies, our health, and ourselves. In the interest of self-discovery, here are some questions to consider:

- What does having hepatitis C (HCV) mean to you?
- What do you tell yourself about having this virus? What words do you use to describe yourself?
- How do you picture HCV?
- What do your inner voices say to you?
- Are you afraid? Angry? Despondent?

An HCV diagnosis has many meanings for different people. Some describe it as a death sentence. Some people may feel like victims; others feel contaminated. At the other end of the spectrum are those who feel that HCV provides an incentive to stay healthy. They are not just living with HCV, they are thriving with it.

Language is powerful. We use language to form our thoughts. These thoughts influence us – our choices, our health and how we perceive the world. The recognition of the power of thought

has been around for centuries. The most famous example of this is the 17th century philosopher Rene Descartes who posited, “I think, therefore I am.”

When I write this column, I am aware of the power of words. When I describe a person as *someone living with HCV*, it may conjure up a different image than that of an *HCV patient*. The term *healthcare consumer* seems more powerful than the word *patient* does.

Professionally, the word *patient* has powerful connotations. When working with patients, I serve them. Patients have the power to hire or fire me. However, when I am the patient, I have come to associate the word *patient* with a vulnerable and passive condition.

Troubled by my ambiguity, I looked up the word *patient*. The word *patient* comes from the Latin word “to endure pain or suffering.” According to *Wikipedia*, *patient* and *patience* share the same origin. *Wikipedia* gives this further definition: *enduring trying circumstances with even temper*.

This image is powerful. The notion of enduring difficulties while maintaining an even-temper seems like a lofty goal. Perhaps it is enough to endure, regardless of temperament. However, to endure with minimal anxiety or even with grace is very attractive to me. It makes being a patient a noble condition.

What do you say to yourself? What messages do you send to your body, mind, and spirit? Do not be afraid to look at yourself, to find your truth and name it. Perhaps the answers to these questions may deepen our discoveries about ourselves, enabling us to live in health rather than in disease. May the year ahead be filled with patience and dignity.



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HIV) continues to show great promise for the treatment of HBV, but has not yet been approved by the FDA for the treatment of HBV.

NEEDLE EXCHANGE AND SYRINGE PHARMACY SALES:

There were three states (Massachusetts, Delaware, and New Jersey) that passed laws authorizing the sale of syringes or approved the use of needle exchange in 2006. 2006 was THE year that every state in the United States had needle exchange or lawful syringe sales laws on the books. We have a long way to go before we catch up to other countries in regard to helping to prevent the transmission of blood borne pathogens among injection drug users, but we are well on the way. **Massachusetts:** In 2006 a law was passed by the Massachusetts state House and Senate to authorize the sale of syringes without a prescription to anyone who is 18 or older. The bill was vetoed by Governor Romney, but the veto was overridden by the Massachusetts House and Senate to become law. Four counties in Massachusetts already have established needle exchange programs. **Delaware:** In 2006 a law was passed that legalized needle exchange in Delaware after more than 10 years of legislative effort. **New Jersey:** On December 12, 2006 New Jersey passed a measure (S 494) that would establish needle-exchange programs in six cities and provide \$10 million to drug treatment programs in the state. Ongoing advocacy efforts have led to strides in the approval of syringe sales in California. In 2004 **California** passed a law that authorized individual cities and counties in California to lawfully

sell syringes. Since the law went into effect on January 01, 2005, 14 counties (Los Angeles, Santa Barbara, San Francisco, Contra Costa, Yuba, Marin, Santa Cruz, Alameda, Yolo, San Mateo, Solano, Sonoma, Humboldt, and Santa Clara) and 4 cities (Los Angeles, West Hollywood, San Diego and San Francisco) have implemented the law. Sixteen counties/cities are considering implementing the law.

HEPATITIS C RESEARCH:

In 2005 I reported on many news stories that advanced our knowledge of the hepatitis C virus. These included a story about scientists from the National Institutes of Diabetes and Digestive and Kidney Diseases (NIDDK) who were the first to replicate the hepatitis C virus in a test tube. Other advances in the understanding of the hepatitis C virus came from researchers from UC Berkeley who discovered how the hepatitis C virus ‘hijacks’ cells in its replication process. Rockefeller University was also able to produce an infectious form of HCV in a laboratory culture made up of human cells, and they were able to identify the molecule that plays an important role in the entry of HCV into the host cell. University of Texas Medical Center discovered how the hepatitis C virus promotes liver cancer and how the hepatitis C virus ‘short-circuits’ the immune system with the HCV NS3/4A protein. Johns Hopkins University School of Medicine also produced HCV in a test tube.

In 2006 there was also much research into the mechanism of action of the hepatitis C virus. Probably the biggest news in 2006 was the ability of researchers at Rockefeller and Philip Meuleman at Ghent University in Belgium to infect two chimpanzees and a mouse model bearing human liver grafts

from an isolated form of HCVcc (hepatitis C virus cell culture) developed at Rockefeller. In addition the researchers found that the infected models could infect other mice and from these blood samples HCV could be easily re-cultured in a test tube.

No less impressive is the news from the University of Texas Medical Branch about the first laboratory cultivation of HCV genotype 1. Earlier in the year, Cai and colleagues replicated HCV genotype 2a in a test tube, but the culture of HCV genotype 1 is seen as a huge step forward in research because it will afford a way to study the virus more closely to find out how the virus evades the immune system, what will kill the virus (and what will not kill the virus) and to develop new therapies to treat hepatitis C.

Johns Hopkins also reported this year that it is finding out how HCV is able to block the immune system’s reaction to HCV by constantly mutating, which allows the virus to evade the immune system. It was found that when the virus is under attack from the immune system, it will mutate and change from the original strain (consensus strain) using viral mutations, but once the virus effectively evades the immune system, it will revert back to the original strain. The scientists also noted that “the hepatitis C virus naturally mutates, or alters its genome, very rapidly. The strains of HCV have two to three times more genetic variability, for example, than HIV, the virus that causes AIDS, and hepatitis C reproduces more than 100 billion times per day, 100 times faster than HIV.” In another study, Johns Hopkins teamed up with researchers in Ireland to compare the genetic changes

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across multiple genes in strains from chronically infected people to the original strain that infected them. The scientists believe that they have found the original strain or 'ancestral' strain that could be used to develop a protective vaccine for all types of hepatitis C.

Other items of note include: **Statins** are medications that are used to treat elevated levels of cholesterol. The use of statins in someone with chronic liver disease comes with a warning of potential hepatotoxicity. In 2006 a study on veterans with and without HCV was released. In this study, it was found that the incidence of severe hepatotoxicity, or discontinuation of statin therapy were similar in the hepatitis C-positive and -negative patients. The authors also went on to comment that the use of statins in people with hepatitis C appeared to be safe. Another study looked at the potential for using statins for the treatment of hepatitis C. In a study published in the July 2006 issue of *Hepatology*, Masanori Ikeda and colleagues found that statins may actually inhibit the hepatitis C virus from replicating – at least in the test tube. The activity against hepatitis also depended on the statin used. Fluvastatin (Lescol) demonstrated the strongest activity against HCV, while other statins had moderate to no effect. But before you rush out to your doctor to ask about these medications to treat hepatitis C it is important to remember that the study was carried out in test tubes and has not been studied in humans. The preclinical data looks good, but we are a long way off from using these medications to treat hepatitis C. **Coffee** was also in the news

and the research looks encouraging that a small amount of coffee may actually improve the overall functioning of the liver and may prevent cirrhosis. Of course, more carefully designed prospective studies are needed to confirm these results.

CURRENT HCV THERAPIES:

With all the hype about new drugs in development it is easy to forget the great strides that have been made in HCV treatment. 2006 produced a wealth of information about higher treatment responses with individualized treatment (duration of treatment and drug dosing) based on a person's viral load, genotype, liver histology, age and how long someone has been infected. Also, information was garnered about predicting response to therapy based on viral load reduction after 4 weeks of therapy (rapid virological response) and tailoring treatment for the best possible outcome. Other improvements were seen in the understanding and management of HCV treatment-related side effects. Probably the biggest news is the clear evidence that in people who achieve an SVR (and even in those who do not) liver health can be improved, and the rate of ongoing disease progression slowed. Also trials have found that people with decompensated cirrhosis, who are followed VERY closely (usually transplant centers) to monitor for accelerated disease progression, can be successfully treated, which may improve liver histology and delay the need for liver transplantation.

A special thanks to C.D. Mazoff, Martha Saly, Glen Backes, and Mindy for their help in compiling this review.



EXCITING NEW PUBLICATIONS FROM HCSP

HEPATITIS C

HCSP GUIDES

- *A Guide to Understanding Hepatitis C (2006)*
- *For Family and Friends: Caring for Someone with Hepatitis C*

MEDICAL WRITERS' CIRCLE

- *HIV-HCV Coinfection Update*

HCSP FACTSHEETS

Hepatitis C Basics:

- *Fatty Liver*
- *What Is Fibrosis/Cirrhosis?*
- *New HCV Antivirals and Drug Resistance*
- *HCV Viral Load Tests (2006)*

HCSP Factsheet Series

- *HCV Viral Load Tests*
- *Predictors of HCV Treatment Response*

HEPATITIS B

- *Hepatitis B: What You Need to Know*
- *What Are Antivirals?*
- *HBV: Drugs in Current Clinical Development*
- *What's New in Hepatitis B Treatment*
- *Which Antiviral to Use First*

HIV/HCV Coinfection News from AASLD and HIV8



Liz Highleyman

The 57th annual meeting of the American Association for the Study of Liver Diseases (AASLD), held in October in Boston, and the 8th International Congress on Drug Therapy in HIV Infection (HIV8), which took place in Glasgow in November, both featured several presentations on HIV/HCV coinfection.

LIVER FIBROSIS AND CIRRHOSIS

People with HIV/HCV coinfection appear to experience more rapid liver disease progression than individuals with hepatitis C virus (HCV) alone, though this may be less common among patients with well-controlled HIV and preserved immune function.

Spanish researchers reported on a retrospective study of HIV positive patients seen at Hospital Carlos III in Madrid since October 2004 (HIV8 abstract P319; AASLD abstract 740). Using the noninvasive FibroScan elastography method, they found that 182 out of 2,155 HIV positive patients (8%) had liver cirrhosis (defined as a liver stiffness measurement above 12.5 Kpa). The prevalence of cirrhosis was 1% in individuals with HIV alone, 6% among patients with HIV and hepatitis B virus (HBV) coinfection, 19% among HIV/HCV coinfecting subjects, 27% among patients with evidence of hepatitis delta virus (HDV) infection, and 66% among patients triply infected with HIV, HBV, and HCV. Individu-

als with and without cirrhosis were equally likely to have HIV viral loads below 50 copies/mL, but those with cirrhosis were twice as likely to have CD4 cell counts below 200 cells/mm³ (25% vs 12%). “Liver cirrhosis is quite prevalent among HIV positive patients with chronic hepatitis C, particularly if HBV coexists,” the researchers concluded. However, they noted that nearly 10% of HIV positive subjects with cirrhosis were not coinfecting with HBV, HCV, or HDV, leading them to suggest that antiretroviral drugs used to treat HIV might contribute to liver damage. Unlike HIV/HCV coinfection, HIV/HBV coinfection did not increase the risk of cirrhosis, probably due to the widespread use of antiretroviral drugs such as tenofovir (Viread) and lamivudine (3TC; Epivir) that are also active against HBV.

The Hospital Carlos III team (HIV8 abstract P313) also reported that in addition to CD4 cell depletion, patients with advanced fibrosis were more likely to have insulin resistance and liver steatosis (fat accumulation), as reflected in higher blood glucose and triglyceride levels. Patients with advanced fibrosis had a longer mean duration of use of protease inhibitors, which have been associated with elevated blood fats and insulin resistance.

FIBROSIS PROGRESSION OVER TIME

Researchers from Johns Hopkins

(AASLD abstract 164) presented data from a study of fibrosis progression over time in coinfecting individuals. They examined paired liver biopsies from 174 non-cirrhotic HIV/HCV coinfecting patients (95% with genotype 1), performed a median of 2.9 years apart; 13% received hepatitis C treatment between the two biopsies. On the initial biopsy, 49% of patients had no fibrosis (stage F0), falling to 39% by the second biopsy. Conversely, the rate of moderate-to-severe fibrosis/cirrhosis (stage F2 or higher) rose from 22% on the first biopsy to 32% on the second. Overall, 24% of patients experienced fibrosis progression of at least two stages, while 22% had a one-stage change, and 48% had no change. The researchers concluded that the current recommendation to offer hepatitis C treatment on the basis of a single biopsy may not be appropriate for coinfecting individuals, who instead “should be closely monitored for liver disease progression.”

LIVER STEATOSIS

In another presentation (AASLD abstract 1254), French researchers reported that liver steatosis was significantly more common among HIV/HCV coinfecting compared with HCV mono-infected individuals. Looking at 123 coinfecting and 482 HCV mono-infected patients,

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they found that 67% and 40%, respectively, had steatosis of any grade. Coinfected patients were especially likely to have a mixed form of macrovesicular and microvesicular steatosis (52% vs 12%). The coinfecting group also had higher rates of severe histological activity (77% vs 55%) and severe fibrosis (34% vs 15%). After adjusting for potential confounding factors, the investigators determined that steatosis was associated with severe histological activity in coinfecting patients and with genotype 3 HCV in monoinfected patients, suggesting different mechanisms underlying steatosis in the two groups. This study, too, suggested that antiretroviral drugs may play a role, since microvesicular steatosis is associated with mitochondrial toxicity, a potential side effect of anti-HIV drugs including ddI (Videx) and d4T (Zerit).

NONINVASIVE FIBROSIS ESTIMATION

The Spanish study described above suggested that FibroScan is a useful method for estimating liver disease progression in HIV/HCV coinfecting patients. In another presentation (AASLD abstract 1051), researchers reported on a study of FibroScan and various biochemical markers (APRI, Forns index, FIB-4) for diagnosing fibrosis in this population. The researchers compared biopsy results and scores from noninvasive methods for 543 patients with chronic hepatitis C, 184 of whom were HIV positive, at two centers in France and Spain. This study also found that fibrosis was more severe among coinfecting individuals compared with HCV monoinfected individuals, with median liver stiff-

ness measurements of 13.8 vs 8.7 kPa. FibroScan estimated that 30% and 56% of coinfecting and HCV monoinfected patients, respectively, had absent or minimal fibrosis (stages F0-F1), while 35% and 15%, respectively, had cirrhosis (stage F4). The biochemical methods also yielded higher scores for the coinfecting patients. Here too, among the HIV positive subjects, those with CD4 cell counts greater than 350 cells/mm³ were less likely to have stage F3-F4 fibrosis than those with lower CD4 counts (42% vs 65%).

HEPATITIS C TREATMENT

At the Glasgow conference, researchers presented the latest data from the Spanish PRESCO trial of hepatitis C treatment in coinfecting individuals (HIV8 abstract PL13.1). This prospective open-label trial included 389 previously untreated HIV/HCV coinfecting participants with CD4 counts above 300 cells/mm³ and elevated ALT levels; 61% had genotype 1 or 4 HCV, while most of the rest had genotype 3. Two-thirds had HCV RNA levels greater than 500,000 IU/mL at baseline. All participants were treated with 180 mcg/week pegylated interferon alfa-2a (Pegasys) plus 1000-1200 mg/day weight-based ribavirin. In addition, some subjects were treated for longer than the standard duration of therapy. Patients with genotypes 1 or 4 were treated for either 48 (n = 192) or 72 weeks (n = 45), while those with genotypes 2 or 3 were treated for either 24 (n = 96) or 48 weeks (n = 56).

Using an intent-to-treat analysis, 50% of patients overall achieved sustained virological response (SVR): 72% for genotypes 2/3, 36% for genotype 1, and 33% for genotype 4. Post-treatment relapse occurred in 35% of genotype 1

patients and 20% with genotype 4, but was uncommon among genotype 2/3 patients. Participants receiving a longer course of therapy were more likely to achieve SVR (53% with 72 weeks vs 31% with 48 weeks among genotype 1 patients; 82% with 48 weeks vs 67% with 24 weeks among genotype 2/3 patients), but the treatment discontinuation rate was high in the extended-duration arms.

SVR rates in the PRESCO trial were higher than those observed in the pivotal APRICOT trial, in which coinfecting patients received Pegasys plus a fixed dose of 800 mg/day ribavirin (40% overall; 29% for genotype 1; 62% for genotype 2/3). "Both the use of higher ribavirin doses and extended duration of therapy most likely explained the better responses in this study compared to prior trials conducted in coinfecting patients," the PRESCO researchers concluded.

Based on a comparison of results from APRICOT, PRESCO, and a third trial of Pegasys plus 1000-1200 mg/day ribavirin in HCV monoinfected patients (HIV8 abstract P314), researchers determined that rapid virological response at Week 4 (13%, 31%, and 33% with undetectable HCV RNA, respectively) and early virological response at Week 12 (37%, 84%, and 84%, respectively) were superior in the two trials using weight-based ribavirin, with responses in the HIV/HCV coinfecting patients nearly as high as those seen in individuals with HCV alone.

For complete conference coverage, see:

- AASLD: www.aasld.org
- Congress on Drug Therapy in HIV Infection: www.hiv8.com



INDIANA DONOR REGISTRY

Here is a myth about organ donation: *When people want to donate their organs, the hospital staff will not try to save their lives.* This is false. Physicians and nurses are trained to fight for the lives of their patients. It does not make sense that they would let a patient die if they could otherwise save them. Do not let this myth prevent you from giving the gift of life – be an organ donor.

Indiana residents who wish to donate their organs upon death may register at *www.donatelifelifeindiana.org*. Indianans may indicate their wish on their state driver’s license or identification card. Remember, even if you do this, you should tell your family about your wishes.

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Self-Care for Hepatitis C ~ Applied Meditation for a Healthy Liver

I believe that the body and the mind are connected. For instance, if I told you to close your eyes and imagine that you have just bitten into a huge juicy lemon, you might begin to salivate. You may even have puckered a bit. The mere visualization of biting into a lemon causes a physical response. This is an example of the mind-body connection.

In spite of my strong belief in the mind-body connection, I am a skeptic. When given the opportunity to review the CD *Self-Care for Hepatitis C ~ Applied Meditation for Hepatitis C*, I accepted the assignment with the intent to find flaws. I just was not feeling open-minded the day I popped it into the CD player. However, within a few minutes, I was unable to resist the encouraging words of Robin Roth or the soothing exhortations of Margo Adair.

Self-Care for Hepatitis C is an opportunity to connect the mind and the body. Although the CD focuses on the liver, it is entirely holistic. Adair takes you through three guided meditations that are relaxing and affirming. The accompanying booklet supports the CD by offering self-care tips.

There is a warning on the CD label telling the listener not to listen to the CD while driving. The first time I listened to the CD, I fell asleep. Fortunately, I was in bed rather than behind the wheel of a car. Each time I felt calmer after listening to it. That alone is worth the price of the CD.

Adair and Roth provide a service to patients with liver disease.

Anyone who believes in the mind-body connection is likely to appreciate *Self-Care for Hepatitis C*. Even skeptics might appreciate it.

Self-Care for Hepatitis C ~ Applied Meditation for a Healthy Liver, by Margo Adair and Robin Roth. CD and 32 page booklet \$18.95. Order at: www.hepCmeditations.org

– Review by Lucinda Porter, RN

Some other publications on HCV and liver disease that you may find helpful.

- *Dr. Melissa Palmer's Guide to Hepatitis and Liver Disease*, by Melissa Palmer.
- *The First Year-Hepatitis C: An Essential Guide for the Newly Diagnosed*, by Cara Bruce, Lisa Montanarelli.
- *The Hepatitis C Help Book – A Groundbreaking Treatment Program Combining Western and Eastern Medicine for Maximum Wellness and Healing*, by Misha Ruth Cohen, Robert Gish, Kalia Doner.
- *The Liver Disorders Sourcebook*, by Howard J. Worman
- *Living With Hepatitis C For Dummies*, by Nina L. Paul, Gina Pollichino
- *Living With Hepatitis C: Everything You Need to Know*, by Jenny Heathcote, Colina Yim, Quynh Thai, Averell Sherker
- *Living with Hepatitis C: A Survivor's Guide (Third Revised Edition)*, by Gregory T. Everson, Hedy Weinberg
- *My Mom Has Hepatitis C*, by Hedy Weinberg, Shira Shump, Gregory T. Everson, Joy Chen
- *Hepatitis Magazine* – www.hepatitismag.com



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