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HCV in Prisons

Alan Franciscus, Editor-in-Chief

People incarcerated in prisons and jails who are infected with hepatitis C represent the largest group of any population infected with hepatitis C. It is estimated that about 1.4 million people with hepatitis C are released from incarcerated settings every year, which accounts for about 1/3 of all the people infected with hepatitis C in the United States. In fact, hepatitis C is now the leading cause of illness and death in some prisons and jails.

This article will summarize information contained in a publication titled "Opportunities to Address the Hepatitis C Epidemic in the Correctional Setting" by Amy E. Boutwell and colleagues which originally appeared in *Clinical Infectious Diseases*¹

The imprisoned population in this country has increased dramatically over the last 2 decades from 313 prison and jail inmates per 100,000 persons in 1985 to 702 prison and jail inmates per 100,000 persons in 2002. By 2002 (the last year data is available) there were over 2 million people in the United States who were incarcerated – the largest percentage of incarcerated people out of the total population of any country in the world.

Drug-related crimes have dramatically increased over the last 20

years – from 40,000 to 450,000. In fact, 83% of prisoners in state institutions and 73% of the incarcerated in federal prisons report past drug use. Regarding injection drug use, 20% of state inmates and 13% of federal inmates report a history of injection drug use.

It is not surprising that, based on the reported drug use of the incarcerated population, there is a high prevalence of hepatitis C. Various states have estimated that the prison population infected with hepatitis C is between 29 and 42% depending on the state. Nationally, it is estimated that between 15% and 30% of all prisoners may be infected with hepatitis C, which is 8-20 times higher than the general population. The prevalence of HIV and hepatitis C coinfection in prisons and jails is also a concern since it is estimated that there are 100,000 HIV/HCV coinfecting people who are released from correctional systems each year.

Given the high rate of hepatitis C in prisons many experts view this as a perfect opportunity to address the hepatitis C epidemic by providing diagnosis, prevention and, if needed, treatment that would benefit millions of Americans and have a great impact on the hepatitis C epidemic nationally. Many would argue that this is a public

IN THIS ISSUE



HCV and Fatigue.....3

Fulminant Liver Failure.....5

Extrahepatic Manifestations:
Sjögren's Syndrome.....8

health problem since the majority of people who are imprisoned return to their communities. If hepatitis C is left undiagnosed and untreated, experts believe that hepatitis C positive prisoners released back into their communities will pose a public health problem by continuing to practice unsafe behaviors that will put these communities at risk. In addition, if their hepatitis C infection worsens then the community at large will have to bear the brunt of the medical and economic burden of hepatitis C.

The Centers for Disease Control and Prevention (CDC) and the American Public Health Association have issued guidelines for the screening and management of hepatitis C in correctional settings, but due to several factors listed below the guidelines have not been implemented in every state. This, however, is slowly changing as more programs and services are being developed across the country.

continued on page 2

PRISONS

continued from page 1

CHALLENGES OF TESTING, MANAGEMENT AND TREATMENT

There is a belief that if you offer testing you must offer treatment, and many prison officials believe that the costs associated with treatment could bankrupt the prison healthcare budget. However, if the premise that not everyone in the general population needs to be treated is instituted in prisons and if treatment is only given to those whose sentence is longer than the duration of treatment, costs associated with hepatitis C screening, prevention and, possibly, treatment would be feasible. The authors pointed out that in their experience well-developed systematic evaluation and treatment programs account for less than 5% of the total correctional health care service budget – based on a state facility with an HCV prevalence of ~25%. They note as well that there are further challenges treating prisoners, such as the frequent transfer of prisoners within and between institutions, high turnover rates and the length of prison sentence.

Another concern is that prisoners are a more difficult population to treat because of pre-existing psychiatric and drug abuse problems, but the authors noted that in Rhode Island there were 93 prisoners who were identified for treatment and only 3 prisoners were excluded because of unstable mental illness. Almost all of the patients reported a history of drug abuse, and 76% reported prior injection drug use. Psychiatric side effects of HCV treatment were of concern to the officials, but there were no treatment discontinuations due to psychiatric problems, and no reports of thoughts of suicide or attempts

to commit suicide. There was a general overall sustained virological response SVR (HCV undetectable during and six months post treatment) of 43% which is only slightly lower than the SVR rates observed in the general population.

IMPLEMENTATION OF GUIDELINES

Even though there are guidelines from the CDC and the American Public Health Association that support the screening, education, counseling, referral for substance abuse counseling, and medical treatment for inmates infected with hepatitis C, many states have not instituted the guidelines. However, many states do seem to be developing programs to address the hepatitis C epidemic in prisons. This is in part due to public health concern, inmate health issues and, most notably, litigation that has taken place in various states including Montana, New Jersey, Michigan, Maine and Oregon. The authors noted that “[a]lthough consensus is emerging slowly, it is becoming widely accepted that access to antiviral therapy for inmates cannot be categorically denied, and guidelines allowing reasonable access to care are becoming the norm.”

It was also noted that the most beneficial lessons learned from HIV/AIDS treatment programs can be used as a model for instituting HCV programs. In addition integration of hepatitis C services into existing HIV/AIDS programs would be effective although more research is needed to completely understand and address the unique issues of HCV.

RESEARCH IN PRISONS

One avenue for addressing the HCV issue in prisons is through clinical trials. Currently, there is a need for more research on hepatitis C in the prison population. One concern

about conducting research in the incarcerated population is that there is a risk that prisoners may be forced to participate in a trial or they may not be properly informed about the potential harm of an experimental drug. This fear is due in large part to practices in the past when prisoners were used in experiments without regard to their health and safety. In fact, many federal and state prisons prohibit experimentation on prisoners or greatly restrict research. However, the authors point out that, if studies are conducted in an ethical manner, research will greatly benefit the prison population. “Physicians and researchers must persevere in efforts to decrease barriers to appropriate research about conditions that disproportionately affect prisoners as a class and demonstrate that this research is necessary and, when appropriately conducted, ethical, because it stands to benefit a particularly underserved group of people.”

The authors concluded that, despite the barriers to identification, prevention, management, and treatment of hepatitis C, services for hepatitis C are possible and needed because of the epidemic of hepatitis C in prisons. “This will be best achieved by collaboration between public health officials and the corrections system.” Furthermore the authors note that all stakeholders will need to be involved in the process, including granting agencies to support research to affect a change in current conditions and to prevent the future burden of hepatitis C in correctional settings.

Reference:

1. Opportunities to Address the Hepatitis C Epidemic in the Correctional Setting, Amy E. Boutwell, Scott A. Allen, and Josiah D. Rich. *Clin Infect Dis*. 2005 Apr 15;40 Suppl 5: S367-72



HealthWise:

HCV and Fatigue



Lucinda K. Porter, RN, CCRC

Fatigue is a common complaint heard from people living with chronic hepatitis C virus (HCV) infection. Although not terribly painful, chronic unmanageable fatigue can be debilitating. It is a symptom without any visible proof. It is not considered life-threatening except perhaps if you are too tired to drive or operate heavy equipment safely. Yet few symptoms can disturb quality of life more than relentless fatigue can.

Before you assume HCV is causing your fatigue, rule out other factors. Start by talking to your doctor. Fatigue is a symptom of many conditions other than HCV infection. Common examples are thyroid dysfunction, anemia, depression, sleep apnea and perimenopause. Report all drug and supplement use to your medical provider. Include vitamins, herbs, over-the-counter and recreational substances as well as prescribed medications. These may be contributing to your fatigue.

Fatigue is also a common side effect of HCV treatment. Again, talk to your doctor about this. Other medical conditions can occur during HCV treatment. Anemia, depression, and hypothyroidism are side effects of HCV therapy associated with feelings of exhaustion. These can be treated.

Your doctor may suggest medication. Antidepressants, especially bupropion (Wellbutrin), are sometimes used for fatigue. There are other medications that are used for extreme fatigue which your doctor might suggest. Examples are modafinil (Provigil), ondansetron (Zofran), and methylphenidate (Ritalin). Methylphenidate is a controlled drug, so tell your doctor if you have a history of substance abuse.

Assuming you have already consulted your doctor, then examine three important factors that influence energy levels: sleep, nutrition and exercise. Inadequate or poor quality sleep can lead to feelings of daytime tiredness. Make sure you are getting sufficient sleep. The National Sleep Foundation states that the average adult needs 7 to 9 hours of sleep per night.

Be sure to eat food with high nutritional value. Fruits and nuts are good choices. Eat small, frequent

meals. Make sure you are taking sufficient quantities of vitamins and minerals. Stay well-hydrated by drinking plenty of water. For the average adult, this means drinking a half to a whole gallon of water daily.

Light exercise is probably the single most effective antidote for fatigue. This is hard to believe, especially if getting out of bed is an ordeal. When you do not feel like moving, move anyway. As a popular advertisement says, "just do it." Try 10 to 15 minute intervals, 2 to 3 times daily. If you are not accustomed to physical activity, start slowly and for shorter, less frequent periods. Some activities to try are walking, biking, swimming, dancing, gardening, Yoga, Tai Chi, Qigong, and Pilates.

TIPS FOR MANAGING FATIGUE

- Stress can be draining. Learn relaxation techniques.
- Unmanageable pain can be exhausting. Seek help for this.
- Vary activities – don't sit too long or stand too long.
- Balance rest with activity. Try to rest **before** you get too fatigued.
- Rest even if you aren't tired. This may help you avoid future fatigue.
- Take short naps – no more than 20 minutes and not close to bedtime.
- Take a shower. Alternate water temperatures from hot to cold.
- Spend 5 or 10 minutes in the sun.
- Practice good posture.
- Stretch.
- Avoid alcohol, tobacco and recreational substances.
- Make sure your room is sunny or well-lit.
- Ask for help.
- Create short cuts.

continued on page 4

FATIGUE

continued from page 3

- Organize your work areas so you can work more efficiently.
- Make sure your indoor space is well lit.
- Schedule your most demanding tasks for the time in the day when you are usually at your best.
- Take “mini” vacations. Spend an afternoon doing something you really enjoy.
- Rub your earlobes for at least 7 seconds.
- Find ways to laugh.
- Practice deep breathing for a minute whenever you feel tired.
- Try Chinese Medicine or hypnosis.

Attitude cannot cure fatigue, but it can be a powerful ally. Watch the negative “self-talk.”

When all else fails, laugh. There is no doubt about it; fatigue puts a damper on life. However, humor with fatigue is more tolerable than misery with fatigue. The choice is yours.

SUPPLEMENTS ASSOCIATED WITH FATIGUE MANAGEMENT

Dietary supplements share some common properties with drugs in that they have side effects, interact with other substances and should be avoided by some people in some circumstances. Always talk to your medical provider before using supplements. (For more information see the HCSP Factsheet *Herbs and Hepatitis C.*)

Medicinal herbs and supple-

ments should not be taken by patients with cirrhosis or by transplanted organ recipients unless specifically ordered by their physician followed by clearance from their liver specialist. All dietary supplements should be discontinued at least one week prior to any dental or medical procedure that has a bleeding risk or uses anesthesia.

Here are some dietary supplements that have been associated with fatigue management and are considered generally safe for average adults. Ginseng is the most researched one on this list:

Coenzyme Q10 (CoQ10) – Insufficient information is available to establish the efficacy of CoQ10 for relief of fatigue. Rare reports of

continued on page 7

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Fulminant Liver Failure

■■■
Liz Highleyman

Fulminant hepatitis (also called fulminant hepatic failure, or FHF) is acute, rapid liver failure that may be caused by viruses, toxins, autoimmune reactions, or a variety of other factors. Though uncommon, FHF is a serious and potentially fatal condition. HCV infection alone rarely leads to acute liver failure, but people with chronic hepatitis C are more susceptible to FHF due to other causes. Fortunately, there are several steps you can take to reduce your risk.

FHF RISK FACTORS

It is estimated that there are about 2,000 cases of fulminant liver failure in the U.S. each year. Various studies show that perhaps 12-15% of these are due to viruses; around 10% are linked to acute hepatitis B and 5% or so to acute hepatitis A. Looked at another way, only about 1% of people with acute hepatitis A will develop FHF. Coinfection with hepatitis delta virus (HDV) increases the risk that patients with HBV will experience acute liver failure. Hepatitis E can also cause FHF, especially in pregnant women. Experts believe a vigorous immune response - rather than the viruses themselves - is responsible for liver injury.

While acute hepatitis C rarely if ever causes sudden liver failure by itself, chronic hepatitis C patients who become coinfecting with hepatitis A or B are at risk for FHF. In one study, Sandro Vento and colleagues found that in a cohort of 17 chronic HCV patients who later were infected with HAV, seven (about 40%) developed FHF

and six died. This is why it is so important for HCV positive people to get vaccinated against HAV and HBV.

Other viruses including cytomegalovirus, varicella-zoster, and herpes simplex 1 and 2 can also cause acute liver failure. In addition, Vibrio viruses present in undercooked shellfish can cause rapid and severe liver damage in people with pre-existing liver disease (see July 2005 HCV Advocate).

Besides viruses, toxins are the other main cause of fulminant liver failure. Many agents can cause liver toxicity, such as Amanita ("death cap") mushrooms, organic solvents, and several different classes of drugs. But the biggest culprit by far is acetaminophen, found in Tylenol and numerous over-the-counter and prescription preparations. Most acetaminophen-related liver failure cases are suicide attempts, but taking recommended doses of the drug can also sometimes cause severe liver damage, especially when used by people with existing liver disease or when combined with other drugs or even moderate amounts of alcohol (see January 2005 HCV Advocate).

MANAGING ACUTE LIVER FAILURE

Regardless of its cause, the course of acute liver injury is similar. Decompensated liver failure occurs when the organ is so damaged that it can no longer carry out crucial functions such as filtering the blood and synthesizing important proteins.

Early symptoms resemble

those of other types of liver-related illness: nausea, loss of appetite, abdominal pain, fatigue, and flu-like symptoms. Patients may then develop jaundice (yellowing of the skin and eyes). Serious deterioration may occur within hours or days (as with acetaminophen poisoning), or over several weeks or even months. Officially, FHF refers to hepatic encephalopathy (brain dysfunction) and coagulopathy (blood clotting problems) that develop within eight weeks of initial illness in a person who was previously healthy. Acute liver failure that develops within 26 weeks is referred to as "subfulminant" or late-onset, while sudden liver failure in a person with existing chronic hepatitis is technically known as "acute-on-chronic."

There is no definitive treatment for acute liver damage. Unlike other organs, the liver can regenerate if the initial cause of injury is eliminated, but this process takes time. For a few causes, liver deterioration can be halted if diagnosed in a timely fashion. N-acetylcysteine is an effective antidote for acetaminophen toxicity if administered within about 48 hours, and penicillin G and silymarin (milk thistle) are used to treat Amanita mushroom poisoning. But in other cases, medical management focuses on supportive care and alleviation of complications resulting from liver failure, including:

- Encephalopathy, believed to be due to build-up of ammonia and other toxins that affect the brain. Symptoms may include confusion, agitation, delirium, increasing somnolence, and eventually hepatic coma. Therapy aims to eliminate toxins by various means including

continued on page 6

LIVER FAILURE

continued from page 5

lactulose, low protein diet, and the antibiotic neomycin.

- Cerebral edema, or fluid build-up in the brain. This can cause elevated intracranial pressure (ICP) - probably the major cause of death related to FHF - which in turn can lead to cerebral ischemia (inadequate oxygen) and herniation (when the lower part of the brain is forced through the hole at the base of the skull). Some of the treatments used to reduce ICP include mannitol (a diuretic), phenytoin to prevent seizures, hyperventilation, and hypothermia.

- Coagulopathy, indicated by prolonged prothrombin time, which can lead to excessive bleeding, including internal bleeding in the stomach and intestines. Therapies include recombinant factor VII and vitamin K to improve clotting and H2 receptor blockers to reduce gastrointestinal bleeding.

- Metabolic imbalances, which may include acidosis or alkalosis (abnormal blood pH, or acid/base balance), hypoglycemia (low blood sugar), and decreased levels of electrolytes such as sodium and potassium. Therapies involve monitoring and supplementation as needed.

- Systemic infection by bacteria or fungi (sepsis). Cultures should be done frequently to check for emergent infections, and antibiotic

and antifungal drugs administered as appropriate.

- Multiple organ failure, which may affect the kidneys, lungs, and cardiovascular system. Supportive care may include hemodialysis and assisted respiration.

The goal of supportive therapy is essentially to buy patients some time for their livers to recover or for suitable donor livers to become available for transplantation. While all patients with altered mental status due to FHF should be considered potential transplant

Preventing Acute Liver Failure: Tips for People with HCV:

- Get vaccinated against hepatitis A and B
- Avoid eating raw or undercooked shellfish
- Do not take more than recommended drug doses
- Do not mix drugs or drink alcohol while you're taking medication
- Tell your healthcare providers about all the medications you are taking, including prescription and over-the-counter medications, herbal remedies, and street or recreational drugs

candidates, it is difficult to know in advance who will recover spontaneously and who will need a new liver. The best predictor is etiology: patients with liver failure due to acetaminophen toxicity or acute hepatitis A are the most likely to recover without a transplant (about 60% and 40-70% in various studies, respectively). In contrast, one study found that the spontaneous recovery rate for FHF due to acute HBV was about 20%, while the chances of recovery from acute liver failure caused by idiosyncratic drug toxicity or autoimmune hepatitis are considerably lower.

Individuals with fulminant

liver failure receive the highest priority score (UNOS status 1) and are bumped to the top of the liver transplant waiting list. FHF accounts for about 10% of all orthotopic liver transplants in the U.S., and the survival rate is as high as 80%. Usually once the new liver is in place and working, encephalopathy, coagulopathy and other symptoms resolve and the recipient recovers fully.

But, unfortunately, there are not nearly enough donor livers to go around. As such, researchers have explored a variety of techniques designed to "bridge" patients to spontaneous recovery or transplant. These include artificial liver support devices (see November 2004 HCV Advocate), extracorporeal (outside the body) human or pig livers, hepatocyte transplantation, and heterotopic or auxiliary liver transplants, in which a donor organ (or a piece of one) is implanted alongside the patient's own regenerating liver. Developing better methods of liver support remains a key goal for future research.

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FATIGUE

continued from page 4

increased liver enzymes. A small study reported organ damage in heart patients using Q10 during intense exercise. Vigorous exercise is discouraged with simultaneous use of CoQ10. Use cautiously if there is a history of diabetes, low blood pressure, thyroid disease or use of anticoagulants (warfarin, aspirin, ibuprofen, etc.) Is known to interact with a long list of other drugs and supplements. No safety data available regarding children, pregnant or nursing mothers. CoQ10 is sold in varying amounts and qualities. These factors coupled with insufficient research supporting the use of CoQ10 for fatigue makes it difficult to establish a recommended dosage.

Cordyceps mushrooms – Very little is known about this fungus. Its purported uses include fatigue and hepatitis. To date there have been virtually no known adverse reactions to cordyceps. Diabetics should use cautiously as cordyceps may lower blood glucose. The “recommended dose” is approximately 1 gram 2 or 3 times daily. Cordyceps has not been tested on children, pregnant or nursing mothers.

Dehydroepiandrosterone (DHEA)– DHEA is a hormone. For this reason, people with prostate or hormone-sensitive cancer should avoid it. DHEA has multiple uses, but there is insufficient information to judge the efficacy of DHEA for fatigue relief. According to Natural Standard, because DHEA utilizes the liver’s “cytochrome P450” enzyme system, it may interfere with the body’s ability to process certain drugs and other dietary substances. DHEA may interfere with clotting ability. Pregnant and nursing women should

avoid DHEA. Not enough evidence to recommend safe use for children. Dosage recommendations unknown.

Evening Primrose Oil (EPO)

– Insufficient information is available to judge the efficacy of EPO for relief of fatigue. EPO interacts with a number of drugs and dietary substances. Contraindicated for those with schizophrenia. Seizures have been reported by people taking EPO in conjunction with certain medications or anesthesia. EPO may interfere with clotting ability. Pregnant and nursing women should avoid EPO. Not enough evidence to recommend safe use for children. Dosage recommendations for fatigue not established.

Ginseng (many varieties) – This herb has been widely studied and has earned a prominent reputation in Chinese medicine. Purported to improve mental ability and fatigue along with many other uses. Some of these uses are supported by clinical data and have earned the approval of a number of worldwide organizations, including the World Health Organization (WHO) and Germany’s Commission E. The “recommended dose” is 100 mg of standardized ginseng extract 1 to 2 times a day. Should not be taken continuously. If taken continuously for 2 weeks, discontinue for 2 weeks before restarting. Contraindicated for those with hypertension. Multiple side effects and warnings, including cardiac, bleeding, and manic symptoms. May alter blood pressure, blood glucose levels and liver lab results. May interact with many drugs including warfarin, aspirin, ibuprofen, naproxen, MAO inhibitors, calcium channel blockers, digoxin, and opioids. The list of other herbs and dietary supplements that ginseng may interact with is considerably long. Should not be

used with other stimulants, including excessive caffeine. Not enough evidence to recommend safe use for children. Ginseng should be avoided by pregnant and nursing women and those with breast cancer. Andrew Weil, MD suggests using American ginseng since the Asian variety is associated with insomnia, irritability, and increased blood pressure. He also states that “real ginseng” contains ginsenosides.

Rhodiola (Rose Root) – May help fatigue. Very little is known about this herb. To date there have been no reported adverse events. May cause irritability or insomnia. Use very cautiously with bipolar disease since rhodiola may act as an antidepressant. The “recommended dose” is 100 to 200 mg 2 times a day. No safety data available regarding children, pregnant or nursing mothers.

Resources

- American Botanical Council - www.herbalgram.org
- Center for Science in the Public Interest: Nutrition Action Health Letter <http://cspinet.org>
- ConsumerLab.com - www.consumerlab.com
- Drugs.com: Drug Information Online - www.drugs.com (You can use this website to check the interactions between all your medications and dietary supplements.)
- iherb - www.iherb.com/health.html
- Memorial Sloan-Kettering Cancer Center - www.mskcc.org/about/herbs
- National Institutes of Health National Center for Complementary and Alternative Medicine - <http://nccam.nih.gov>
- Natural Standard - www.natural-standard.com



Extrahepatic Manifestations: *Sjögren's Syndrome*



Alan Franciscus, Editor-in-Chief

Sjögren's ("SHOW-grins" syndrome) is an autoimmune disorder that has not been directly linked to hepatitis C, but is seen more often in people with hepatitis C than in the general population. The exact cause of Sjögren's is unknown, but heredity, viral infections and, possibly, hormones may be contributing factors. There also seems to be a link between Sjögren's and rheumatic disorders such as rheumatoid arthritis.

Sjögren's can affect many parts of the body, but most often affects the tear and saliva glands. Sjögren's is classified into two types: primary which occurs alone and is not associated with any other factors or conditions, and secondary which occurs because of other conditions such as viral infections – hepatitis C.

Sjögren's syndrome affects between one and four million Americans – about one to two percent of the population. It generally affects people between 45 and 55 years old, although it can affect anyone regardless of age. It is also found mostly in women – women are 10 times more likely to have Sjögren's than men.

SYMPTOMS

The symptoms of Sjögren's include dry and painful burning in the eyes and dry mouth which can lead to difficulty eating and swallowing dry foods. There may

also be swelling of the glands around the face and neck. Other symptoms can include fatigue, joint pain, and dryness of the nasal passages, throat, vagina and skin. Sjögren's can affect the kidneys, lungs, liver, pancreas, blood vessels and the brain, but this is uncommon. Most people with Sjögren's syndrome are able to live normal and healthy lives.

DIAGNOSIS

The diagnosis of Sjögren's syndrome is made by a variety of methods including physical examination, blood tests, biopsy and special studies. There are various lab tests used to diagnose Sjögren's that may include measuring the amount of tear or saliva production and a blood test to detect antibodies characteristically found with Sjögren's. Other factors such as medications should be excluded since the side effects of some medicines can mimic the symptoms of Sjögren's.

TREATMENT

Sjögren's syndrome can not be cured. The most common treatment of Sjögren's is to lessen the symptoms with the use of preservative-free artificial tears and eye drops to reduce the inflammation around the eyes.

PRIMARY CARE GUIDE

The Hepatitis C Support Project is very excited to announce a new educational tool recently posted to the HCV Advocate Web site:

Management of Hepatitis C by the Primary Care Provider: Monitoring Guidelines, by Drs. David H. Winston, M.D., PACP and Donna C. Winston, PhD, NP.

This comprehensive guide is the perfect tool for anyone working in hepatitis C. It was written to help guide providers and patients in the task of medically managing hepatitis C. Topics in the "Guide" include:

- * The HCV Virus
- * Natural History of HCV
- * Screening for HCV
- * Evaluating Patients with HCV
- * Counseling Patient with HCV
- * Treatment of HCV
- * Side Effect Management

This publication is the result of a joint venture by the Hepatitis C Support Project and the National Partnership for Wellness.

continued on page 9

SJÖGREN'S

continued from page 8

To relieve the symptoms of dry mouth there are medications to stimulate the production of saliva. Drinking plenty of clear fluids such as water is also recommended. Additional strategies to help dry mouth are to suck on sugar-free candy, chew sugar-free gum and use saliva substitutes. Avoid any food, beverage or medication that contains sugar, alcohol, or caffeine and stay away from spicy or acidic foods. There are also prescription medicines such as Evoxac to help maintain the flow of saliva

It is important to practice good oral hygiene care since a decrease in salivary flow can cause dental cavities, gum infections, and oral yeast infections.

Most people with Sjögren's will have a healthy and productive life, but some people may develop serious complications. If you believe you have Sjögren's talk to your medical provider about diagnosis and treatment. Treatment generally consists of managing the symptoms of Sjögren's since there is no cure at this time.

For more information on Sjögren's syndrome:

- Sjögren's Syndrome Foundation
www.sjogrens.org
- Arthritis Foundation
www.arthritis.org

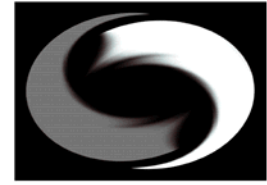


NEW: A GUIDE TO HEPATITIS AND DISABILITY

The Hepatitis C Support Project has recently posted A Guide to Hepatitis and Disability on our Web site www.hcvadvocate.org that is one of the most comprehensive documents available on how to prepare and file for social security disability. Included in the Guide is helpful information on how to prepare and file for long and short term disability insurance. There is additional information on commercial disability insurance, and health insurance. There is also information on what to do if your claim is denied and a comprehensive list of web site links to and contact information for various state and federal social security offices.

This document was prepared by Christine Kukka and Jacques Chambers from a compilation of articles by Jacques Chambers found in his monthly Benefits Column, which appear on our web site at :
http://www.hcvadvocate.org/hepatitis/living_w_hepatitis_C.asp

We would be very interested in hearing from our readers about their experiences when filing for social security. If you would like to share your experience, please contact Alan Franciscus at
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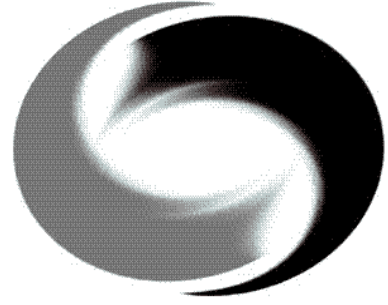
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