



Canadian HIV/AIDS Pharmacists Network (CHAP) Newsletter - May 2001

Hello Network Members!

This newsletter is my last official responsibility as chair as I will be turning over the chair to Glenda at the upcoming CAHR meeting. It has been a great year (and a bit) serving as the chair of the network! I will soon be off starting a new role as "mommy". I plan to stay on the email distribution list so I can try to "keep up" so I hope to continue to interact with all of you. My home email address (effective May 11) is christine_hughes@canoemail.com. Please update your address books. I will also let all of you know when my bundle of joy arrives!

Good News Items....

I would like to congratulate Alice on her recent marriage. Congratulations Alice and best wishes!

I would also like to wish Ann Beardsell all the best in her career change for the upcoming year. Ann's new email at work is ann.beardsell@scchc.bc.ca.

Upcoming Conferences

CAHR

CAHR will be held May 31- June 3, 2001 in Toronto. Hope all of you attending have a wonderful time!

ICAAC

The 41st ICAAC will be held September 22-25, 2001 in Chicago, Illinois. The deadline for abstracts was April 25, 2001. Early registration deadline is July 20.

Drug Availability - Updates

Amprenavir

Amprenavir received NOC/C March 1, 2001 and will be marketed under the brand name Agenerase®.

Lopinavir/ritonavir

Lopinavir received NOC March 9, 2001 and will be marketed under the brand name Kaletra®.

Dapsone

(Linda)

We received a fax March 26/01 which indicates Wyeth Ayerst is discontinuing Avlosulfon effective immediately & they give 1-800-461-8844 # to try to obtain further information & a request form for physicians requiring continued access to Dapsone through SAP. BUT, when we called for an order form, it indicates that Medis Healthcare will ship the product to the designated physician/hospital pharmacy within 2 business days of credit card authorization! This will be a problem as first of all it is the community pharmacies who obtain this item for outpatients in Sask. & secondly whose credit card is going to be used??! They're using a U.S. product approved by FDA & we don't know if the cost will be significantly higher as it's relatively cheap now.

(Pierre)

I spoke with Stewart Hill from Wyeth-Ayerst - Presently they are looking into reimbursement issues. For the moment, dapsone is not being reimbursed by provincial formularies. The cost is \$19.55 for a bottle of 100 tabs. He will let me know as soon as reimbursement is settled. His phone number is 1-800-461-8844 press 1 then 1 again.

Clinical Pearls

1. ddl and d4T in pregnancy

IMPORTANT DRUG WARNING

January 5, 2001

Dear Healthcare Provider,

Fatal lactic acidosis has recently been reported in pregnant women treated throughout gestation with the combination of stavudine and didanosine. Based on these cases, the combination of stavudine (ZERITÂ) and didanosine (VIDEXÂ or VIDEXÂ EC) should be used with caution during pregnancy and is

recommended only if the potential benefit clearly outweighs the potential risk, such as when there are few remaining treatment options.

This recommendation is based on three cases of fatal lactic acidosis, two with and one without pancreatitis, that occurred in women who were either pregnant or postpartum and whose antiretroviral therapy during pregnancy included stavudine and didanosine in combination with other antiretroviral agents. Two of the infants of these women died, one in utero at 32 weeks gestation and one after emergency caesarian section at 36 weeks gestation. Two of the fatal cases occurred in patients enrolled in BMS study AI424-007, an open-label, multinational, randomized, two-arm comparison of stavudine plus didanosine plus nelfinavir (Viracept®) versus stavudine plus didanosine plus BMS-232632 (an investigational protease inhibitor). A third pregnancy-related death attributed to lactic acidosis was reported through worldwide postmarketing surveillance. This patient had received long-term therapy with stavudine and didanosine together with the NNRTI nevirapine (Viramune®). In addition, postmarketing surveillance identified several nonfatal cases of pancreatitis, with and without lactic acidosis or hepatic failure, in pregnant women receiving stavudine plus didanosine.

PATIENT MANAGEMENT

Stavudine and didanosine are nucleoside reverse transcriptase inhibitors indicated for use in combination with other antiretroviral agents for the treatment of HIV-1 infection. The nucleoside analogue class of antiretroviral drugs has been implicated in idiopathic lactic acidosis and severe hepatomegaly with steatosis, and all members of this class carry a warning in the label to this effect. Data have suggested that women may be at higher risk for these toxicities and it is unclear whether pregnancy potentiates these known side effects. However, the temporal occurrence of the three deaths should serve as a reminder that potential risks may be associated with use of these agents in pregnancy. Decisions regarding antiretroviral therapy for pregnant women are complex and should be made by healthcare providers experienced in the treatment of HIV infection. Although the VIDEX (didanosine), VIDEX EC (didanosine), and ZERIT (stavudine) labels have always advised of the risks of lactic acidosis, Bristol-Myers Squibb has decided to expand the Boxed Warning, Warnings, and Precautions sections to reflect the new information that has been described above. For the complete Warning on lactic acidosis and the Precaution regarding the use of these agents in pregnancy, please see the enclosed full prescribing information.

The revised Boxed Warning statements for both the didanosine and stavudine labels are stated below:

Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogues alone or in

combination, including didanosine (stavudine) and other antiretrovirals. Fatal lactic acidosis has been reported in pregnant women who received the combination of didanosine and stavudine with other antiretroviral agents. The combination of didanosine and stavudine should be used with caution during pregnancy and is recommended only if the potential benefit clearly outweighs the potential risk.

Please see enclosed full prescribing information for VIDEX (didanosine), VIDEX EC (didanosine), and ZERIT (stavudine) for additional information regarding the recommended use of these agents.

2. Nevirapine for postexposure prophylaxis

Serious Adverse Events Attributed to Nevirapine Regimens for Postexposure Prophylaxis After HIV Exposures --- Worldwide, 1997--2000**

In September 2000, two instances of life-threatening hepatotoxicity were reported in health-care workers taking nevirapine (NVP) for postexposure prophylaxis (PEP) after occupational human immunodeficiency virus (HIV) exposure. In one case, a 43-year-old female health-care worker required liver transplantation after developing fulminant hepatitis and end-stage hepatic failure while taking NVP, zidovudine, and lamivudine as PEP following a needlestick injury. In the second case, a 38-year-old male physician was hospitalized with life-threatening fulminant hepatitis while taking NVP, zidovudine, and lamivudine as PEP following a mucous membrane exposure.

To characterize NVP-associated PEP toxicity, CDC and the Food and Drug Administration (FDA) reviewed MedWatch reports of serious adverse events in persons taking NVP for PEP received by FDA. The report summarizes the results of that analysis and indicates that healthy persons taking abbreviated 4-week NVP regimens for PEP are at risk for serious adverse events. Clinicians should use recommended PEP guidelines and dosing instructions to reduce the risk for serious adverse events. The complete CDC MMWR report can be accessed at <http://www.hivatis.org/atisnew.html>.

3. Ganciclovir

(Michelle)

I am wondering if your institution has an autosub policy on rounding off ganciclovir IV doses to the nearest 25 or 50mg? This would facilitate batching and pre-mixing. This is something we are exploring at UAH in Alberta. If my memory serves me correctly we used to round off to the nearest 25mg at the Wellesley in Toronto.

(Ann)

We round off to the nearest 50mg. It makes the batch mixing in the sterile

room MUCH easier.

(Natalie)

We usually only have one patient on ganciclovir at a time so it is not an issue for us. I try and round off doses as I write the orders for the physicians or consult as they write them; however, I always recalculate my dose to stay within 10% of the dosing guideline selected.

(Jeff)

The Foothills Hospital doesn't have an official autosub policy for ganciclovir, but the usual practice is rounding to the nearest 50 mg. From our patient population at the Southern Alberta Clinic, we've probably only had two patients on IV ganciclovir as outpatients in the past year, so it hasn't been an issue to date. The docs we work with are pretty reasonable as far as dose adjustments.

4. Polyactic acid

(Laura)

At the 2nd International lipodystrophy/ADR conference, a french group presented the results of a polyactic acid injection for lipoatrophy of face- the results looked promising.

Does anyone know of these injections being available in Canada?

(Ann)

There is a plastic surgeon here that is doing Gortex implants into the cheeks. He then injects one of two products. The expensive one is called Adidostat (I think) which is medical grade microdroplets of silicone. The other is cheaper and is reclaimed material from cadavers - I think it is called "facim" or something like that. Apparently, the Adidostat is much better. The procedure takes about 6mo in total to complete but all the patients have been thrilled with it. I haven't heard of the product that you are asking about but I will check with some of the docs around here.

5. Ganciclovir and J-tubes

(Ann)

We have had a rash of J-tube insertions in the last 2 months (6 to be exact) and one patient is on oral ganciclovir. There is a lot of concern with the RNs opening the capsules and putting the powder into the tube because of the chemo status of this drug. Has anyone run up against this and found a solution? To use the iv formulation in oral dosages is prohibitively expensive. This fellow is slated to go to a residential care facility but they won't accept him if he has IV meds so switching to IV administration is not an option. Any ideas??

6. Medical Marijuana

(Anita Richard / Alfred)

I am looking for a "legal" source of marijuana for a patient whom Dr. Rosser has apparently submitted an application for exemption under Section 56 for Medical Use of Marijuana. I have read the 3 documents pertaining to marijuana in the Health Canada Website (which are somewhat dated), and will try to contact HC on Monday. Does anyone know of a particular contact at HC that I should speak with (to avoid getting the run around)? I believe CSHP was looking for someone to participate in discussions with HC on this issue a while back. Is anyone aware of who that rep might be?

Is anyone aware of a legitimate source of marijuana? Has anyone gone the route of applying for exemption - if so, are patients to find their own source or are they provided with guidance? Thanks for any information you may be able to share!

(Laura)

The contact person at Health Canada is Nicole Metivier (tel #) 613 946-6478. We have around 10 patients who have access to legalized marijuana.

They don't have to buy from a legalized source. Patients are expected to find their own source - I believe.... There are allowed to buy and grow their own. (ie allowed to have 3 immature and 4 mature plants in their possession).

7. ddl Suspension

(Laura)

A patient of ours (advanced AIDS, CMV retinitis, on salvage regimen) is mixing his ddl suspension with chocolate milk (heard about being able to mix the tablets with chocolate milk).

He is also on ganciclovir po.

I phoned BMS to look into the chocolate milk/ddl liquid mix - they were very convinced that chocolate milk should not be mixed with ANY type of ddl product. They say that ddl (tablets) mixed with 2 tablespoons of milk decreased AUC by 16% (wouldn't think this is significant?).

I'm thinking he has ganciclovir which is probably compensating for any decreased exposure of chocolate milk, besides - he is on a salvage regimen and he needs the ddl (we have tried all the standard tricks to improve palatability of tablets).

Any advice you have would be SOOO appreciated. Can't wait for the EC formulation to become available!!

(Ann)

We have always suggested chocolate milk (1/2 glass) as an option and there has never been any obvious problem to date. The other option that a few patients did (they were lactose intolerant) was to mix the ddl in the regular fashion but add chocolate syrup to it. Whatever works!! Some also tried Koolaid crystals. I am sure that we got word back from BMS that milk was ok but that would have been several years ago. Another trick that most patients have found that helps is if the suspension is cold. So what a lot do is to put the tablets (usually 4 at once) in the glass of water, cover it with plastic wrap and leave it in the fridge. They usually do this at bedtime and then get up first thing in the am and drink it (after stirring). They then can eat or have coffee 0.5-1hr later. The taste isn't so bad if it is cold- so I am told. In addition, the dose is done for the day and they don't have to think about it again until bedtime. We are lucky as we do have some EC through a study so we have been able to keep people on who really cannot stand it.

(Kathy)

My patients absolutely LOVE the DDI pediatric suspension. When reconstituted with Maalox it is just 20cc of yummy cheery stuff once a day. ie we no longer use the tablets.

(Alice)

I was definitely told by BMS years ago that the chocolate milk thing was OK, and patients were just advised to drink it within 1/2 hour of mixing.

(Ann)

Yes, we are also using A LOT of cherry Maalox but our dose is 40ml of 10mg/ml suspension once daily. Are you mixing it differently than the company directions?? The biggest problem with the suspension is the 30 day expiry and the refrigeration. We try to teach patients to mix their own but many cannot or won't or don't have a fridge. So this makes for extra visits than the regular every 2 month pickup. For our daily dispensing sites, we or the off-site pharmacists make the suspension up in bulk 4L bottles and dispense from that. Currently, the 4L lasts about 2-3 days at each site!!

(Kathy)

We make a concentrated sol (20mg/mL) Data from company & we get pts to make up after they are taught. They all have fridges.

(Natalie)

There is a saccharin sweetened ES Maalox Plus (cherry-flavoured) that can be

used to reconstitute the ddl but our kids prefer the regular mint-flavoured Mylanta. Because of a recently published study in pediatrics that permits ddl to be given with food (lower fraction absorbed with food offset by the absorption rate becoming rate-limiting for elimination because children's metabolism is so fast). In other words, we give ddl with milk or formula for our young kids but ask adolescents to do the empty stomach, 60 ml milk thing. I also was part of the discussion at one of our previous network meetings that concluded that 16% decrease in AUC was not significant especially if the alternative was nonadherence.

8. Antiretrovirals and tube feeds

(Christine)

We have a patient who is newly diagnosed and developed a number of complications during her hospital stay. She ended up with a tracheal tear (requiring placement of a stent) and a G-tube for feeding. I have not seen this patient in clinic yet but the homecare nurse was concerned about administering her medications with her tube feeds. Apparently she has been very nauseated and they have turned her feeds down (so she needs it for 16 hours per day). They also want to push the tube further into the jejunum. They are concerned about her aspirating as a result of the stent. She is currently on AZT, 3TC, efavirenz, cotrimoxazole, and azithro suspension. I cannot find anything in the literature but based on the kinetics of these drugs, I don't think I would be worried about administering with tube feeds with the exception of azithro. However, my other question would be whether the placement of the tube would be a concern? If anyone has any experience with this (perhaps the pediatric group), I would appreciate your thoughts.

(Natalie)

I do not know the location of absorption for the drugs you listed. However, at CHEO we have had HIV+ patients with gastric-jejunal tubes (we can them G-tubes for short) without problems of absorption that we can detect - same viral loads, CD4 counts, & ADRs pre & post tube insertion.

(Ann)

We have had 5 patients in the last 2 months have J-tubes inserted (none for years and then 5!!). There has never been any obvious absorption problems. If the meds need to be on empty stomach, they just stopped the feed for an hour or two or organized the feeds around the meds. The biggest struggle has been getting liquid formulations for some of them. We have found out that GW does have liquid abacavir (unbeknownst to even the reps) but there is not a huge supply available in Canada. We have also found out that you can get ABT378/r in liquid formulation through the expanded access program. The ganciclovir oral administration we are still struggling with due to the

cost of using the iv formulation in oral doses (about \$300/day) and the issues around handling of a chemo drug (opening capsules etc).

9. ALR Beepers

(Alice)

I was just speaking with our Merck Frosst rep, and wanted to get an idea of how many people are still giving ALR beepers to their patients. Merck is starting to feel that since more people are going over to BID indinavir/ritonavir regimens, there is "no need" to worry about strict timing of doses anymore, so they are evaluating whether or not to continue funding the ALR beepers. Granted, the ALRs are often really annoying and don't have the best quality control track record, but a lot of our patients still really depend on them, even those with fairly simple (BID/TID) regimens since there really isn't an available alternative. Are other people still using them a lot?

(Christine)

We do not use them as much as before (i.e. when pts used tid indinavir), HOWEVER we still do use the ALR beepers quite a bit. They are particularly valuable for patients who have a bit more chaotic lifestyle (i.e. no regular routine) and I would say they are very important for adherence.

(Lori Esch)

We are still using ALRs or alternate beeper sources for our patients quite a bit, even with BID regimens (occasionally they only want the beeper to remind them of a single daily dose). Although people are not all in agreement as to their usefulness, I agree they are an important tool to be able to offer select patients.

(Lizanne)

A lot of our patients, including those on a BID schedule, also find the ALR beeper very useful and count on it. I hope Merck continues to fund this.

(Ann)

We still use a lot of them - when they work. We have started using more of the black ones (long, 8am-11pm, MedTimers) as the ALRs weren't working reliably for a long while.

(Linda)

Yes, I still use them quite frequently as Christine says the new patients we are seeing have "chaotic" lifestyles & the beepers seem to help them even tho' they are mainly using BID schedules. We would miss them if they were not available.

(Kathy)

We still use them quite frequently

(Alice)

Thanks for everyone's feedback. I guess the best thing to do is to keep on encouraging our Merck reps to support the ALRs for as long as possible.

(Yvonne)

I went to a presentation last night where the speaker (an American) said that in the clinic she works in the beepers have been replaced by watches that the patient programs themselves. It also gives a digital display of what the patient is supposed to take at that time - really cool she said - the patients love them. I assumed (perhaps incorrectly) that these were supplied by Merck because of the way she referred to the watches replacing the beepers. Does anyone know? Has anyone used them? Is it just an American thing?

(Lori)

I believe the watches that she was referring to were the HealthWatch 100. We are using them in our adult and pediatric populations (although we do the programming instead of the patient because we are trying to use them in the context of a small study of their usefulness). I, too, am in the US so it may be irrelevant, but here, Merck is NOT paying for them. They are rather expensive (I was able to get a bulk rate of \$60 US each). We have just started using them so I don't have much feedback yet, but I will keep you posted.

10. Revised Manitoba Health Post-Exposure Protocol

(Alfred)

Here is a link to the PDF file by MB Health entitled "Integrated Post-Exposure Protocol: Guidelines for managing exposures to blood/body fluids"

Several changes related to Hep B+C and lastly advice on ARTs side effects.

<http://www.gov.mb.ca/health/publichealth/cdc/fs/IPEP.pdf>

11. Headaches

(Deborah)

We have a patient who has been experiencing severe intractable headaches (which required hospitalization for nearly 3 weeks!) that we suspect are related to his ARV.

He was started on nevirapine, AZT and 3TC in August (previously treatment

naive), with no problems until after Christmas when headaches began. CD4 >500, all medical investigations (cultures, CT, LP) negative for medical cause. AZT only was d/c for 5 days before patient came to us, with no improvement in headache, so it was restarted again. Of note, WBC and neut declining over past week and half (WBC now around 3.5; was >7 and neut now around 1). Decided to stop all ARV and now headache resolved! WBC still low, but stable. Suspected BM suppression due to AZT, but what to make of headache?

Have you seen delayed headache with any of the ARV? In particular we are now wondering about the NVP, but I haven't found anything of this nature reported. Curious for your thoughts...

(Lizanne)

I haven't come across that side effect at the clinic. If you cannot find anything re his ARV, it may be worth exploring food or other types of allergies/intolerance, and smoking habits (one of my non-HIV patients during the PharmD suffered from severe headaches for months before we found out they were caused by the nicotine gum).

12. Lopinavir Levels

(Christine)

Is anyone out there able to do lopinavir levels? We have a guy who we think is malabsorbing based on his 24 hour fecal fat. Based on genotyping, he is only resistant to the NNRTIs and yet has had no response to a lopinavir-based salvage regimen (compliance okay).

If you are able to, can you provide any details re: the cost, where to send blood, how much blood and shipping requirements?

(Lizanne)

I called Abbott regarding this issue before and after Christmas. Currently, blood levels can only be measured in the States (by Covance labs in Chicago I think). Apparently a Centre in Vancouver will eventually have the assay to measure ABT-378/r blood levels, but Abbott was not sure when and no other centre in Canada has it. We did not pursue the idea because of the complexity of shipping blood to the States and of the time it would have taken to get levels back (our patient was at the end of her pregnancy). Another difficulty is that we do not have standard measurements to compare blood levels against. The person I spoke to at Abbott was Dr. Nabil Abadir, Medical Adviser, Scientific Affairs : 514-832-7255.

(Ann)

I spoke with our guy that is setting up the mass spec here and he may be able to run the level for you. I guess that there are limitations around

the assay, esp low levels. He was going to check to see if he could do out of province levels and let me know tomorrow. Are you still wanting to do this??

13. Cidofovir

(Kathy)

I think that there was some recent discussion about using cidofovir topically for resistant HSV. We have a gentleman with a huge penile ulcer that is TK deficient & therefore will not respond to ganciclovir or acyclovir. We are reluctant to use Foscarnet IV as his Cr is bad. Any thoughts?? I appreciate it.

(Christine)

I don't have any experience with topical cidofovir but there are some papers in the literature about it (sorry I didn't keep the abstracts). In follow-up to my patient that had acyclovir-resistant herpes, he received a course of cidofovir IV and is now pretty much 100% (although this doesn't really help your patient if his renal function is quite poor).

Going back to our previous discussion on cidofovir, this was Tony's response: I have used topical cidofovir for several patients with anal warts and molluscum contagiosum. I have compounded a 3% cream in an inert base (e.g. Glaxal base), and have had the patient apply it to the affected areas once daily. Most of the time, there is not 100% clearance of the warts, but patients have noted improvements in the size of the lesions or the total area affected.

Another option worth a try might be imiquimod 5% commercial prep'n (contact 3M pharmaceuticals) three times a week.

For acyclovir resistant herpes, never made up topical foscarnet; usually use the IV form. Cidofovir gel has been noted to work as well, although I've never tried it for anyone. I believe there may actually be a 1% gel available for this indication, but would have to check with Gilead on it's status/availability.

If you want to call Gilead to inquire about the gel, you could try 650 522 5881. This is the number one of my patients gave me as a contact (Debbie Fletcher, Director of Marketing, U.S.).

14. Pentamidine

(Kathy)

Our hospital has recently started to use Falding pentamidine (generic) it is not indicated for INH. The brand name product (Aventis) is indicated IM/IV/INH. Have any of you guys used this (the Falding product) for inhalation. I am sure that it is fine but I want to double check

15. G-tube

(Laura)

Any advice you have would be great.

We have a guy in hospital, he's getting a G tube in today. He'll be in hospital getting radiation etc for the next 4-6 weeks.

He's on ABT-378r, d4T and ddl.

We will probably get d4T suspension through SAP and probably ddl pediatric powder for suspension. Finally we are thinking about requesting the liquid form of ABT-378r from Abbott (supposedly the contents of the gencaps may crystallize in the tubing, but could be flushed with acidic media).

Does any of you, especially those working on the inpatient side of things have any insight to add?

(Ann)

We used the liquid formulations of all three.

16. Cidofovir for PML

(Deborah)

Does anyone have any experience obtaining cidofovir for treating PML? My understanding is that it is available via Special Access, HPB, but since the drug is approved in US for CMV, not sure if they would approve our indication.

17. Herbal Treatment for HIV

(Jeff)

Hi all....FYI, there's a herbal product that's popped up in ads in the gay papers here in Calgary, I'm not sure if they've made it across the country yet, but the company is also marketing on the web (address is www.viraltreatments.com). The product "TLB" is made by an herbalist here in Alberta, and is being marketed by a Calgary businessman. They do have clients using the stuff in the U.S., and I know of a few of our patients whose attention has (not surprisingly) been caught, and a couple have opted to stop ART (or worse, continue with both). The recent ads have been (probably) in offense of the Health Act regulations regarding allowable advertising. The ads I've seen state that the product "has not been proven in HIV, but is 100% antiviral and antifungal, and 50% antibacterial". Interestingly, one of our obstinate patients who chose to d/c his ART and use TLB recently came down with thrush! I know the ads cannot make a statement about use of the product for hepatitis; advertising for HIV is less clearly defined by Health Canada at this time. At any rate, I've discussed the

(un)appropriateness of the ads with an inspector from Health Canada, after expressing concerns to the marketing company and the publishers of the gay paper here in town. The inspector has a number of possible courses of action: stopping sale, seizing the product already manufactured, stopping that line of advertising, etc..... He will follow up with me.

I met with the businessman selling the stuff some time ago. He spoke of doing "clinical trials", and there's a kind of a dicey doctor in the city which may be involved, but they're probably not approved trials and I don't know how they're structured. The contents of TLB include: echinacia, lemon balm, pau d'arc, St. John's wort, garlic, and two other herbs that I can't remember off the top of my head right now.

Has anybody else come up against this stuff yet? Anymore info that you want, let me know!

18. Photosensitivity and antiretrovirals

(Laura)

Does anyone know if photosensitivity can be a problem with either efavirenz or Combivir?

I have contacted the companies. Right now the evidence seems to be comprised of a few case reports of photosensitivity - but it doesn't seem like it happens commonly.

(Alice)

I remember that zidovudine can sometimes increase melanin production so that people look more tanned, even without going into the sun (not necessarily a bad thing for most).

Reports from Working Groups

Publication Group (Sandy)

At the upcoming CAHR meeting, for the publications group we could discuss the website paper or what other papers of interest the group has in preparing...eg. a detailed paper on adherence, TDM etc.

Research

The pregnancy survey has been finalized and has recently been distributed electronically by Christine Hughes. The deadline for return of the physician surveys to the network members is June 30, 2001. Completed surveys can then

be forwarded to Alice Tseng who is collating the data. The report will be written by Laura Park-Wyllie.

Communications

No update.

Education (Glenda)

No update.

Additional News

Updated Guidelines

*****Perinatal Guidelines Updated, January 24, 2001*****

The HIV/AIDS Treatment Information Services (ATIS) announces the release of the updated Public Health Service Task Force Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States guidelines.

*****Adult and Adolescent Treatment Guidelines Updated February 5, 2001*****

The updated (February 5, 2001) Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents (The Living Document) is now available through the ATIS Web site.

*****Adult and Adolescent Treatment Guidelines Updated April 23, 2001*****

The updated (April 23, 2001) Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents (The Living Document) is now available through the ATIS Web site.

All of the updates are to the section, Considerations for Antiretroviral Therapy in the HIV-Infected Pregnant Woman. The updates begin on page 28 of the document. Please note that the highlighted (shaded) sections of the document include the updates released in the February 5, 2001 version.

In Print

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Diarrhea and abnormalities of gastrointestinal function in a cohort of men and women with HIV infection, Knox,T.A., Spiegelman,D., Skinner,S.C., Gorbach,S.: Am.J.Gastroenterol.,95 (12):3482-3489 (2000 Dec)

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Determinants of Antimicrobial Prophylaxis Use and Treatment for Wasting among Patients with Advanced Human Immunodeficiency Virus Disease in the United States, 1995-1998. Edward L. Murphy, Susan F. Assmann, Ann C. Collier, Timothy P. Flanigan, Princy N. Kumar, Fran R. Wallach, Sharon Krubel, and for the Viral Activation Transfusion Study. Clin Infect Dis.,3(1): 116 (2001 Jan 1).

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Many of you have probably seen this story but for those who haven't.....

THE CRACKED WATER POT

A Water bearer in India had two large pots, each hung on each end of a pole which he carried across his neck. One of the pots had a crack in it, and while the other pot was perfect and always delivered a full portion of water at the end of the long walk from the stream to the master's house, the cracked pot arrived only half full.

For a full two years this went on daily, with the bearer delivering only one and a half pots full of water in his master's house. Of course, the perfect pot was proud of its accomplishments, perfect to the end for which it was made. But the poor cracked pot was ashamed of its own imperfection, and miserable that it was able to accomplish only half of what it had been made to do.

After two years of what it perceived to be a bitter failure, it spoke to the water bearer one day by the stream. "I am ashamed of myself, and I want to apologize to you." "Why?" asked the bearer. "What are you ashamed of?"

"I have been able, for these past two years, to deliver only half my load because this crack in my side causes water to leak out all the way back to your master's house. Because of my flaws, you have to do all of this work, and you don't get full value from your efforts," the pot said.

The water bearer felt sorry for the old cracked pot, and in his compassion he said, "As we return to the master's house, I want you to notice the beautiful flowers along the path." Indeed, as they went up the hill, the old cracked pot took notice of the sun warming the beautiful wild flowers on the side of the path, and this cheered it some. But at the end of the trail, it still felt bad because it had leaked out half its load, and so again it apologized to the bearer for its failure. The bearer said to the pot, "Did you notice that there were flowers only on your side of your path, but not on the other pot's side? That's because I have always known about your flaw, and I took advantage of it. I planted flower seeds on your side of the path, and every day while we walk back from the stream, you've watered them. For two years I have been able to pick these beautiful flowers to decorate my master's table. Without you being just the way you are, he would not have this beauty to grace his house."

Moral: Each of us has our own unique flaws. We're all cracked pots. But it's the cracks and flaws we each have that make our lives together so very interesting and rewarding. You've just got to take each person for what they are, and look for the good in them.

There is a lot of good out there. There is a lot of good in us! Blessed are the flexible, for they shall not be bent out of shape.

Remember to appreciate all the different people in your life!
Thank you for being my crackpot friend.