Canadian HIV/AIDS Pharmacists Network
Association Canadienne des Pharmaciens en VIH/SIDA

2008/09 CHAIR
Linda Akagi, B.Sc.Phm.
(Vancouver, BC)

SECRETARY
Cara Hills-Nieminen,
B.Sc.Phm. (Edmonton, AB)

Members of the Working Group:

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Christine Hughes, Pharm.D.
Jeff Kapler, B.Sc.Pharm.
Kathy Lee, Pharm.D.
Jinell Mah-Ming, B.Sc. Phm.

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Gloria Tsang, B.Sc.Phm.

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Lizanne Béïque, Pharm.D.
Norman Dewhurst, B.Sc.Phm.
Charles laPorte, Pharm.D., Ph.D.
Pierre Giguère, B. Pharm, M.Sc.
Linda Robinson, B.Sc.Phm.
Alice Tseng, Pharm.D.
Deborah Yoong, Pharm.D.

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Line Labbé, Ph.D.
Nancy Sheehan, B.Pharm., M.Sc.
Niamh Higgins, Pharm. D.
Rachel Therrien, B.Pharm., M.Sc.

SASKATCHEWAN
Linda Sulz, Pharm.D.

NEWFOUNDLAND
Debbie Kelly, Pharm.D.

CHAP Annual General Meeting Minutes
Westin Bayshore Hotel, Vancouver
MacKenzie Room (main floor)
Wednesday, April 22nd, 2009

Attendees: Linda Akagi (Vancouver-BC), Jinell Mah Ming (Calgary-AB), Carlo Quaia (Vancouver-BC), Deb Yoong (Toronto-ON), Pierre Giguere (Ottawa-ON), Natalie Dayneka (Ottawa-ON), Jeff Kapler (Calgary-AB), Michelle Foisy (Edmonton-AB), Chantal Ho (Toronto-ON), Cara Hills-Nieminen (Edmonton-AB), Christine Hughes (Edmonton-AB), Shanna Chan (Winnipeg-MB), Shannon Stone (Saskatoon-SK), Niamh Higgins (Montreal-PQ), Alissa Koop (Hamilton-ON)

Regrets: Tony Antoniou, Lizanne Beique, Marie Courchesne, Nelson daSilva, Norman Dewhurst, Kevin Duplisea, Deborah Kelly, Kathy Lee, Line Labbe, Charles Laporte, Linda Robinson, Nancy Sheehan, Kathy Slayter, Linda Sulz, Rachel Therrien, Gloria Tsang, Alice Tseng

Business Meeting

1. **Update contact list**

2. **Chap Executive**
New Secretary: Niamh
Chair-elect: Cara
Re-appoint Treasurer: Deb and Alice

3. **Terms of Reference**
Discussion:
-Thanks to Jeff for developing terms of reference and Natalie for updating them.
-General suggestions: adding table of contents and page numbers and letters under numbers for easier referral to points

a. Network Structure:
-treasurer wording:
-re-elected at the annual meeting (Natalie proposed, Jeff second, all in favour)
-add bullet that if anyone interested please contact chair prior to meeting
-need to define executive: Past-chair, chair, secretary, treasurers
-new position-Past chair-assumes this role after 1 year as chair, supports executive as appropriate, finishes responsibilities at next AGM, in conference with chair-decide which tasks to finish off from previous years, collect survey results
-Secretary-keep track of past executive

b. Working group members:
-Need to add Manitoba to working group as now have representation from that area.
-Need to vote on if temporary replacement pharmacist can vote?
-Remove voting by proxy?
-if you don't respond to survey after certain date, you are removed from working group

c. Organization and Operation:
i) Meetings:
New: quorum shall be a majority of working group members attending AGM

ii) Travel grants:
-at the call of the chair, application for travel grants should be made at least 2 mos prior to meeting (in order for others to use extra grants). Then send out email with extra spots to use the grants (for working group members' priority).
-change wording under travel grants from vote to "decide"
-discussion re: new provinces/areas of representation
-Decided that will be discussed every year after survey to see how many people represent each region
-priority for geographic representation and meeting criteria
-changes: Manitoba-one spot
Windsor-decrease to 2 spots
Montreal-decrease to 3 spots
Hamilton-one spot
-additional travel grant allocation may be awarded to the general membership at the discretion of the executive

Action: Natalie will update with suggestions and resend to working group to vote on Terms of Reference

4. **Working group survey:**
Discussion: Reviewed current working group survey that members need to complete yearly if they want to continue to be active members.
-reduced number of responsibilities to at least 3 of 6 (now 5) responsibilities (as listed in Working group members section in Terms of Reference)
- change to # years served on executive (list years)
-remove point #2 and leave point #4 as does not matter if you were leader or just played active role
-#5 list year (not date)
-add point at bottom of survey that if you don't meet working group criteria, and wish to maintain status, please provide additional supporting information. (refer to point 7a under Change of Membership status in Terms of Reference.)

Action: Natalie to update with suggestions and send to working group members to have them complete survey and send results to past-chair (Linda A)

5. **Endorsement guidelines**
Discussion that we need more members to vote:
Action: Linda R to send out to working group for vote via email

Regional Updates:

6. **AAHIVME credential**-Niamh

a. -fee $400 (including textbook), exam 125 multiple choice programs, open book, online (4-6 weeks to complete)
-recertification every 2 years
-only HIV expert credentials
-need 20 CEs in HIV in the year before
-additional membership fee $75
-good review in HIV care but Niamh recommended that person have some experience to take test but textbook is good resource
-can buy textbook separately ($175)

b. -asked by Linda R to review funding for this program. Members at meeting unclear about what our role would be.
Action: Linda R to clarify this interest in funding AAHIVME

7. **Ontario HIV PSG update**-Linda R
-Ontario HIV Pharmacists Professional Specialty Group ministry sponsored continuing education day (March 27/09)-1st time
-3 didactic sessions (Where do the newer agents fit in? Sharon Walmsley; HIV and Hepatitis Co-infection- Michael Silverman; HIV and Cardiovascular Risk-Marek Smieja),
-3 cases from CHAP members (Alice-DI in a CV/HIV patient; HIV in Adolescence and Pregnancy-Natalie; Treatment of the Marginal Population-Deb Yoong)
-videotaped and will be on the Ontario HIV Treatment Network website soon (we will be notified when this is available)
-20-30 pharmacists attended from across Ontario

8. **Quebec TDM Service**-Niamh
-Available nationally
-$60/ sample (+ shipping)
-Niamh gave out CDs/info package
-Certified lab-biochem dept at Mcgill-external
-Turnaround time-2 weeks average
-Reports-sent in mail-or could be faxed-possibility of email
-Interest in TB meds

Roundtable:
9. Discussion re: Toronto Immunodeficiency clinic website
- No new info-under construction
-Will Alice update any tables after PK meeting?
Action: Linda A. to email Alice to ask her

10. Saskatchewan
-very busy-ministry looking at funding 15 positions (at least 0.8 for pharmacist in Saskatoon)
-increase in IV cocaine use
-problem with aboriginal population in denial
-opt-out for pregnant women but not always re-testing at delivery for high risk patients
-peds population increasing (3 to 12 patients, 3 from endemic countries)

11. New Pharmacist information package:
-when we see new members-reach out to them if they are geographically close
-introductory letter from executive and suggestion for a buddy
-shadowing other pharmacists, should CHAP help cover costs for mentorship program
-CCCP member funding, drug company funding, regional funding, hospital funding
Introductory package-Jeff/Deb
-letter to pharmacist
-letter to clinics to let them know we are available??
-one spot to keep PDF files-with Jeff.

Action: Deb and Jeff to look at putting together an information package for new pharmacists. Email Jeff with articles.

12. **Speaker: Dr. Andrew Zolopa**
ART in 2009: Resistance and the Optimal Use of New Anti-Retrovirals
-latent reservoir of HIV
-intensive ART does not impact reservoir (Ghandi et al. 16th CROI)
-RAL-no change in HIV RNA (Jones 16th CROI)
-decline in new cases of resistance from BC data (Lima et al CROI 2008. Abstract 895)
-probably due to better regimens: boosted PIs, easier to take, patient involvement in choice
-declining second virologic failure over time and declining rates of transmitted drug resistance (Jain V, et al. 16th CROI)-better drugs in treated populations, decreases transmission to people not on meds
-start earlier (i.e. higher CD4), less risk triple class resistance (Lodwick R, et al. 16th CROI, Abstract 585)

Question: When are you starting?
AZ-using age approach-i.e. 50 year old men, starting right away, doesn't think they have immunologic reserve; younger, by CD4 350

-everyone should be able to achieve plasma level <50 copies/mL (DHHS Guidelines)
-new steps-integrase, RT, protease –all necessary steps
-CCR5-not constituent step-virus can get into cells another way (i.e. CXCR4)
-more experienced, more dual/mixed tropic virus
-Motivate 1-MVC+OB more effective than OB alone
-R5-may not respond b/c they have X4 hiding-less problem with new assay (Lewis XVI Intern'l HIV Drug Resistance Workshop, June 07, Abstract 56)
-Trofile assay now sensitive in detecting X4 in HIV variants comprising 0.3% of viral populations (Trinh L, ICAAC 08, Abstract 1219)

Question: What about if they change to dual/mixed tropic while on therapy? Will they lose backbone?
AZ-if they suppress-won't switch. Need replicating virus to get the switch.

-asked if anyone using MVC in naïve pts? No one has done it yet-Quebec waiting for tropism to start someone like this. Discussed MVC + CBV wasn't as effective as EFV + CBV but this was with old assay-need new study in naïve population.
-cancer risk? Reviewed data-lots of different cancers, pts were very sick, still a question as we are targeting cell instead of virus.

Question: Is anyone looking at resistance pattern in genome to predict tropism?
AZ-yes, but not sensitive assay. Can't be sure if you don't see them that they are R5 (Genotofino company)
Question: What about the immunologic benefit of CCR5 inhibitors? Would you leave someone on if failing on MVC (know now mixed/dual) to get immunologic benefit?
AZ-thoughts that forcing to dual/mixed would be worse virus. Opposite seems to be the case-better T-cell response. Dampening inflammatory cytokines? Studies being done now to look at using MVC to increase T-cells. May leave on if pt had very good T-cell response with MVC on board and had low CD4 to start with.
Question: What about timing of trofile test?
AZ-can probably do tropism on baseline sample and would reflect virus if pt has been suppressed-not a lot of evolution happening while suppressed.

StartMRK: shorter time to virologic response with RAL vs. EFV and greater CD4 increase with RAL vs. EFV (189 vs. 163) (Lennox J et al, ICAAC 2008, Abstract 896a)
-RAL-no transmitted resistance yet, targeting constituent step, no tests needed before using
-suggests looking at potency article in Nature Medicine /Silicano author
-BENCHMRK-RAL + OB
-resistance is an issue-like NNRTI regimen
-new pathways for integrase-see Stanford website for info
-SWITCHMRK-taken off LPV/r when suppressed and put on RAL
    -better lipids
    -but, less virologic response-breakthrough at 24 weeks
    -relatively fragile class

Question: Michelle has a case of M184V, K103N regimen and on phenytoin-ABC/TDF/RAL???
AZ-in treatment experienced (even minimal mutations), use of integrase inhibitor should be with a boosted PI, evidence based-all studies have boosted PI in regimen
Question: Do you use ABC/TDF together?
AZ-does not use together a lot, does not find combination is any benefit
CHAP members:
unboosted ATV + RAL option
ETV + RAL + nukes option AZ-does think it would be a good combo
Question: What about ETV without boosted PI-no data for that?
AZ-thinks ETV will be reasonable approach but we do need more data

-RAL and EVG-cross resistance (Mccoll DJ XVI HIV Drug Resistance Workshop 2007)
-New generation PIs, NNRTIs: DRV, TPV, ETV-need more resistance mutations (higher genetic barriers)
-new booster-GS 9350-boosting like RTV in 150mg doses (Kearnew B, 16th CROI, Abstract 40) from Gilead
-SPI- 452 another new booster in the pipelines
-ATV 300mg bid + RAL bid–good ATV levels (Zhu 16th CROI Abstract 696.)
-Duet 1+2-pts with > 3 mutations to DRV still had good response with ETV
-ARTEMIS-DRV vs. LPV-non adherent pts did better on DRV (Nelson M 16th CROI Abstract 575)
-NRTIs in experienced pts? ACTG Options trial looking at this
    -3TC-0.5 log despite M184V, fitness vs. anti-viral activity
    -TDF-often phenotype is "sensitive" despite TAMs or K65R
        -0.5 log decrease despite K65R (Nevins AB 15th Internl HIV Resistance Workshop 2006. Abstract 82)
Look at long term toxicity: trying to minimize CV disease, Bone disease, Neuro-cognitive declines

Clinical Forum

13. **10th International Workshop on Clinical Pharmacology in HIV (PK Workshop) Update-Pierre (See attached slides)**

Discussion:
CHAP member: brought up ATV levels may be decreased by RAL
-discussed Mich's case again
PG: suggested ATV 300mg bid added in
Question: What about ATV levels being affected by TDF?
PG: unsure if TDF affects ATV levels enough to worry about boosted vs. unboosted. -Niamh says she sees about 50% of pts on ATV and TDF with low levels in her lab

PG-when changing from boosted ATV to unboosted and also on TDF –uses 600mg ATV dose

14. **Survey re: MTCT kits/Contraceptive options**
    a. -MTCT-Calgary –send protocols to hospitals and they order meds in
    -Quebec-all go to St. Justine
    -Ottawa-all go to TOH
    BC-has kits in 20 sites-site must monitor expiry dates, encourage sites to send back a few months before expiry, covered by CFE
    Deb-idea to survey rural hospitals in Canada to see who is prepared for HIV + moms? And then distribute info on how to order it?

    b. Discussion re: AZT dosing of neonates
    Ottawa-increase dose at 4 weeks
    Alberta: Edmonton-seen at 2 weeks and dose adjusted; Calgary-nurse comes weekly and calls pharmacists and dose adjusted
    BC-do not adjust dose
    Saskatchewan-standard dose if term for 6 weeks
    Ottawa-using 14 day dosing in neonates on Kaletra

    c. Contraceptive options
    Mich-birth control clinic for options
    Carlo-NP in their clinic is prescribing Mirena
    Action: Niamh sending recent articles she has seen on birth control options and HIV

CHAP Initiatives:

15. **Medication reconciliation study-Niamh**

-DEFEAT study-will do med reconciliation on 120 patients (pilot project), find risk factors for errors, then look at larger interventional study-will let us know when they are ready for other sites

16. **NVP/Truvada data-Christine**

-NVP + TDF/FTC or 3TC-did study-presenting at CAHR-high failure rates for naïve pts but switched pts. not many failures
Failures-mutations
Protocol ready. Other sites interested? Pierre, Deb, Niamh
Action: CHAP members to email Christine if interested in participating in study

17. **Kaletra MEMS caps-Linda R**

-Abbott has names of centres interested and will follow up with the centres directly

18. **Nelfinavir PK Aging study-Nancy**

-poster at PK workshop in Amsterdam, needs 14 more patients, negotiating with Pfizer for data from past studies to use to complete study, preliminary data-no affect of aging on levels

19. **New ideas-**
    a. Christine-aging ideas
    b. Deb-list of how you get meds in different provinces
    c. Discussion re: coverage in other provinces, who to contact when they move

    Action: Deb to collate list

20. **ARVs to USA**

-law being changed
-in vitamin bottle
-letter from ID physician
-label in vial
-send ahead and confirm that it has arrived and then don't travel with it
Niamh-document from 2006, in last year's minutes
Deb-Halco-legal group supporting HIV patients
Action: Mich will collate travel ideas.

Minutes recorded by Cara Hills-Nieminen