CHAP Fall 2001 Newsletter

Greetings, everyone! I'm very pleased to be sending out the Fall issue of our Newsletter. Thanks to everyone for their contributions, and also to their input, especially around the revised structure of CHAP. I think that we've made a lot of progress in this aspect since our meeting at CAHR, and we can look forward to an exciting expansion of our network activities. The establishment of the group e-mail list and webpage has also facilitated communications. A brief overview of the newsletter contents follows below. Happy reading!! Alice

News

A beautiful baby girl for Michelle and Kevin!

Olivia Danielle Harris, was born June 15th at 6:13 am after a 9 hour labour, at the Misericordia Hospital in Edmonton, Alberta. Weighing in at 7 lbs 9 oz, and 53 cm long (21"). Congratulations to Michelle & Kevin!

Revised structure/roles & responsibilities for CHAP

Based on the discussions at the annual meeting, the structure of CHAP was modified to include 2 types of membership: general & working group. The purpose of opening up the general membership was to allow more HIV pharmacists across Canada (and even elsewhere) to take part in regular e-mail communications, and attend the general part of the annual meeting. To maintain efficiency, the network felt it was still beneficial to have a smaller working group. A more detailed summary of these changes, along with the outlined roles and responsibilities for working group and general members is attached. Please note the processes for applying for general and working group membership.

A separate **call for candidates** for open spots in the working group will follow shortly.

New members

At this time, we would like to officially say hello to new members which have joined CHAP recently (you may already have noticed their contributions to the discussions on the group e-mail list!):

- Linda Akagi: Ambulatory pharmacy, St. Paul's Hospital, Vancouver
- Jack DaSilva: manager, Ambulatory pharmacy at St. Paul's Hospital, Vancouver
- Anita Richard: Site Manager - Clinical Services at St. Boniface General Hospital and Drug Info Pharmacist, Winnipeg
- Tony Antoniou: HIV ambulatory care pharmacist at the Health Centre at 410, St. Michael's Hospital, Toronto
- Mark Friesen: Winnipeg
- Lizanne Beique: HIV ambulatory pharmacist, Ottawa

Thank you also to everyone who has forwarded names of potential CHAP members to me. I will be contacting them in the near future, and will keep everyone posted.

Changes: The following people have asked to change to a general membership status, and look forward to continued involvement in e-mail discussions and newsletters:

- Martin Boule (Quebec), Alfred Gin (Winnipeg), Yvonne Shevchuk (Saskatchewan)

Other discussions re: membership

Consultants as members:

Debbie: it probably would not be a bad idea to include just to prevent running into problems down the road. I know we didn't discuss this at the meeting, but should we also consider making a statement about industry representatives? If so, we should probably poll the whole group as to what our stand should be.
Linda: perhaps membership could be discussed amongst the core group on a case by case basis
Sandy: I agree with the comments made by Linda and Deborah regarding the consultant's membership...maybe a case by case evaluation?
Laura: I also agree with all other comments from the group
Pierre: I am not so sure that we should elaborate the criteria for being able to join the group. I share your concern with regards to using the network for drug companies profit. But this situation can also happen

from a current member and might benefit other bodies than drug companies. If a statement is to be made, we should not restrict it to <consultant> and make it broad. I think that this could be discussed at a further meeting. For now, I would be in favor of reviewing those requests case by case by the core (working) group.
Jeff: Good idea to broadly control the activities of consultants too - it could be tempting to use information for private gain.

Representation of special HIV populations

(Natalie): As a special interest representative, I would like to see membership on the working group reflect special interests. I would support 2-3 spots reserved for pediatric practitioners. Are they other special interest representatives that should also have reserved spots - for e.g, pre-natal, aboriginal, industry, pharmacokinetists, etc. ? I would support keeping positions vacant until we found a suitable replacement - e.g., Yasmin's position remains open until another HIV research pharmacist is recruited; Regional positions remain vacant until another candidate is located from that region, etc.

(Marie): I think it would be appropriate to add new members with HIV experience but still believe that the number should be limited in order to achieve a consensus at meetings. My experience is that any meeting with 30 people around does not achieve any of the set goals within a limited time frame (direct experience from our HIV clinic meeting!). We always end up having to set sub group who report to the main group and even then agreement on the proposals are difficult to achieve .

I do not know whether elsewhere in Canada there are many people with HIV experience. I kind of disagree that people with only an interest should be part of the group. For me sharing our knowledge and experience is an important part of our e-mail group. In order to contribute to group research people need a certain number of cases . As far as other people with interest only may be our web site could be an alternative for them

(Alice): Maintaining a diversified membership for the working group of provincial delegates is consistent with the original goals of CHAP. Ideally the working group could continue to have representation from all geographical parts of the country, and also a variety of practice specialties if possible.

As mentioned before, the group of provincial delegates is currently comprised of the 20 original CHAP members. Once I have heard back from everyone, then the group as a whole can discuss nominations for any open positions that are available. If there are any particular specialty areas that the members wish to have represented on the working group, then this can be included in the discussion re: potential candidates. For instance, in the past the network has included someone with a background in HIV research. Since Yasmin Khaliq left last summer, the group does not have a member with similar expertise in pharmacokinetics. In terms of pediatrics, the working group currently includes representatives from 2 pediatric HIV clinics (Natalie and Glenda/Dominic Khoo). I'm sure this will be a dynamic process, and there will be plenty of opportunity for everyone to provide input.

Project Updates

CHAP Listserve

We have developed an e-mail listserve on Yahoo groups, to facilitate communications with each other. The name of the group e-mail is: **chap_acpv@yahoogroups.com**
This list is open to the general membership of CHAP, and includes pharmacists who are actively interested in HIV pharmacology and/or practice. This group is a restricted list, which means that new members are added by the moderator (Chair). If there are new members who would like to join, they should e-mail the Chair at chap_chair@yahoo.ca with a request and a brief bio sketch.

Yahoo Groups also provides us with a little homepage for our e-mail group: http://groups.yahoo.com/group/chap_acpv. This page includes a summary of all recent messages, instructions on subscribing or unsubscribing, and a list of members. We have also recently added a **live membership roster** under "Databases", which lists everyone's contact information. Changes can be made directly on the website (better to keep track of those constant hospital mergers!). Again, only network members may access this website.

NB: you do NOT need to access the website to communicate with other members. Just use the group e-mail name as described above to send your questions. This Yahoo site is an extra feature for people who also wish to subscribe to Yahoo. In addition, I will continue to pursue development of a more comprehensive CHAP webpage linked to our clinic website

So far, response to the creation of the listserve has been very positive. The Ontario HIV Pharmacy Specialty Group is now looking at setting up a similar type of listserve for their members.

Website Update

As mentioned above, as an included service with setting up our Yahoo group e-mail account, we have a small website on Yahoo that keeps track of current e-mail list members, all recent e-mail messages posted to the group, as well as the membership roster. Since only network members who are also registered with Yahoo may access this account, we may still wish to develop a webpage on CHAP that is openly accessible to everyone.

I f people are still interested in this idea, I can arrange to have a webpage for CHAP developed and linked to our clinic's website (www.tthhivclinic.com). The webpage can include a description of our group, goals, & mission statement, and will also have copies of past newsletters for viewing in .pdf format. We can decide as a group whether we want to have contact information for individual members, or whether we want to have just a general e-mail address (chap_chair@yahoo.ca) for people to use if they want more information about the network.

Health Canada

I spoke with Suzanne Reid at the CAHR meeting, and she confirmed that there is no need for any further action from CHAP right now regarding the Adverse Event Project. The previous communication from her was an FYI only for our group. She will keep us posted on any new developments. A copy of the report from the Therapeutic Products Directorate, Health Canada about post marketing safety evaluation of antiretroviral therapy is now available: HIV/AIDS Drug Therapies Phase 1 Report - Proof of Concept http://www.hc-sc.gc.ca/hpb-dgps/therapeut/zfiles/english/hiv/hiv-aids_1_e.pdf

In addition, the Canadian Treatment Advocates Council (CTAC) is going ahead with the next phase of piloting their Post Marketing Surveillance System for antiretroviral drugs. I am a member of the Advisory Committee for this protocol, and will also keep people up to date on anything new.

Poster for the International AIDS Conference?

I have been thinking about whether or not we should submit a poster on the creation of the network for the International AIDS Conference next summer? I think this would be of interest and suitable for this type of conference. Much of the information that would be necessary for the abstract has already been organized via the background document on the revised CHAP structure. I would be happy to put a preliminary abstract together, and send it around for people's comments.

Publications/Research

a) Pregnancy survey: 12 completed surveys were returned, and the data have been compiled. Laura is in the process of analyzing and summarizing the final results.
b) HIV Drug Interactions website paper: Since there is currently no universally accepted methodology for reviewing websites, a thorough review of the existing literature will be conducted, prior to development of our protocol. Hence, the revised timeline for this project is suggested:
   - Protocol development with thorough review of literature: January 31st, 2002
   - Website list generation: February 28th, 2002
   - Website review by HIV network members: April 30th, 2002
   - Initial Data Analysis: Mid May ...in time for our HIV business meeting at CAHR. Further project development and avenues for presentation will be discussed at CAHR.

Upcoming Conferences

International Congress on Antimicrobial Agents and Chemotherapy (ICAAC)

By now, everyone knows that the ICAAC meeting was postponed from September 22-25 to December 16-19 in Chicago. More information is available on the website: http://www.icaac.org/

9th Conference on Retroviruses and Opportunistic Infections (CROI)

This meeting will be held February 24-28, 2002 in Seattle, WA. As usual, attendance will be limited to 3800 people. The deadline for abstract submission is October 23, 2001. Abstracts may be submitted on line at http://www.retroconference.org/2002/

Annual Conference on AIDS/HIV Research (CAHR)

This year's Canadian HIV conference will be held April 25-28, 2002 (Thursday to Sunday) in Winnipeg. The deadline for abstract submission is December 21, 2001. More information will be made available on the website www.cahr-acrv.ca. Registration may be done on-line at www.fusionmdnetwork.com. As per usual, we will schedule our annual CHAP meeting to coincide with the meeting, so please set aside some extra time around the conference. We should have a better idea of what dates/times are possible for our meeting once the final program is announced; tentatively, Wednesday April 24th may be an option.

Drug Updates

Tenofovir

(Tony Antoniou): Hi everyone, Just to let you know (in case you didn't already), it looks like tenofovir will be available to Canadian patients within the next month via expanded access.
(Tom Chin): I've been bugging Gilead every now & then. It's not available for Compassionate use yet in Canada as of August, but soon.
(Debbie Kelly): Hi folks: One of our patients told me about the Compassionate Access Program several months ago so I called and my name was put on a waiting list. I was contacted just a couple of weeks ago by a company rep who wanted to find out if our centre was still interested in participating, as it had been several months since we expressed interest. I was told at that time that the details for the program are expected to be ironed out in the next few weeks, and there would be a mailing containing all of the relevant info. I have not yet received the mailing, but did receive the following message yesterday via one of our patients who happens to be a CTAC member. I have copied it below because it contains a phone number for further info.

Letter from Gilead Sciences re: Viread Expanded Access Program Initiated in Canada

Sept 25, 2001

Dear Louise,

I would like to personally thank you and your colleagues again for inviting Gilead Sciences to participate in a very productive and informative meeting earlier this year in Toronto.

Since that meeting, Gilead has made significant progress in addressing the issue of Canadian patient access to Viread (tenofovir disoproxil fumarate), Gilead's investigational once-daily nucleotide reserve transcriptase inhibitor from the treatment of HIV infection. As we discussed in March, we have filed for and received approval from Health Canada to begin offering Viread through an Expanded Access Program similar to our program in the United States. While we are finalizing the informed consent form and other materials following program review and approval by the National Ethics Review Committee (NERC), Gilead is now ready to begin registering Canadian physicians in this program.

The primary objective of this protocol is to provide access to Viread in Canada prior to its commercial availability for patients who have failed commercially available antiretroviral treatment regimens, have limited treatment options and are at risk for disease progression.

The viral load and CD4 cell count entry criteria were established to ensure that patients with the most advanced disease and in the greatest need of a new antiretroviral therapy would have priority in the Canadian Expanded Access Program. These criteria may be modified as the program continues. As needed, we will provide periodic updates to keep you and your colleagues informated about drug availability and any program changes.

Program Overview:

- Study enrollment is currently for patients with the greatest medical need, who meet the following criteria at screening:
  - HIV RNA >= 10,000 copies/mL (by PCR)
  - CD4 cell count <= 100 cells/mm3, and
  - Documented treatment failure with at least two protease inhibitors (PIs) or one non-nucleoside reverse transcriptase inhibitor (NNRTI)
- Patients who have a CD4 cell count between 100 cells/mm3 and 200 cells/mm3 and have had a documented AIDS-defining opportunistic infection with the last 90 days may also be eligible.
- Patients must be at least 18 years of age.
- Tenofovir DF 300 mg, dosed as a single tablet, once daily, will be provided to patients through participating physicians free of charge during the program.
- Physicians will be required to evaluate patients at baseline and after one month on therapy, then every two months until drug discontinuation or study termination following the protocol guidelines. Data collection is limited to the report of serious adverse events, and no specific laboratory testing is required except as indicated for standard medical care.
- The expanded access program will continue until tenofovir DF is commercially available, or until the program is terminated by Gilead Sciences.

We have sent a letter to physicians who have requested information about access to Viread, detailing this program. Please feel free to direct physicians to contact Ingenix Pharmaceutical Services, the contract research organizing managing this program on Gilead's behalf, or the Gilead Sciences Medical Information department at 1-800-GILEAD-5.

We look forward to speaking with you in more detail about this program. I know that David Nathanson is organizing a conference call for the end of October when we also can provide you with an update on our strategy for making Viread available to physicians and patients in Canada.

In the meantime, should you have any questions, please feel free to call me directly at 650-522-5708.

Best Regards,
James F. Rooney, MD
Vice President, Clinical Research

Valganciclovir

Valganciclovir:
Kathy: Has anyone accesssed this yet for their patients ie can it be accessed through special access program with TPP.
Alice: We've been enrolling a number of people through the Valganciclovir Special Access Program. There is a special enrollment form that you can fax in for requests. Patients have to fit in one of the inclusion criteria to qualify (e.g., adherence issues, lack of IV access, catheter-related problems, etc). Once approved, Roche will ship 12 weeks supply at a time. The patients we have on it love the drug - only 2 tabs (900 mg total) once daily with food.
Kathy: Roche told me that enrolment was now closed have you still been enrolling new patients??
Alice: I checked with our nurses, and no one was aware that the program was closed. That being said, the last pending enrollment forms were faxed last month, so maybe this is a recent development. If this is true, valganciclovir must be close to getting its NOC.
Brian Jahns (Roche): I received a limited amount of valgan from my global group. We're currently 80% of the way through our supply, so I think I can fulfill 4 more requests. If I get more drug in, then I can expand it, puruant to the HPB-SAP's approval. They're being pretty tight with regards to entry, and have turned some requests to date. Please call with further questions. Regards, Brian

Brian E Jahns, PharmD, ABAT, Business Unit Manager & Associate Medical Director, Virology HIV, Specialty Business Unit, Hoffmann-La Roche Limited, 2455 Meadowpine Boulevard , Mississauga, Ontario L5N 6L7 Canada. Tele: 001-905-542-5762 Tollfree: 1-800-561-1759 x 5762 Fax: 001-905-542-5581 brian.jahns@roche.com

CLINICAL PEARLS

PEP (Ontario)

Pierre: In Ontario, coverage of ART for PEP is through:
Sunnybrook program: covers AZT for occupational exposure only. It does not cover any other exposure which is not work in nature.
ODB: 3TC for any exposure to suspected HIV fluid (LU code 313); Nelfinavir/indinavir: same as above
AZT 300mg tab: discontinued.
At the OH: Any employee is covered by the Hospital protocol for PEP which include drug coverage for occupational exposure. We also have a sexual assault program that takes care of the cost of ART for Ottawa area (no restrictions)

Difficult situation is when somebody falls into the gap: unprotected sex with documented/suspected HIV individual, needlestick injury in NON occupational exposure (eg parks, garbage...), etc. Then, how do you get ART for those people (those who do not have a drug plan) ?

Another inconsistency: Sunnybrook criteria of use for AZT is different then ODB (ODB being more liberal). What do you do if somebody is on ODB and can not obtain AZT because the NON-occupationnal incident? One solution would be to have Combivir with the LU code 313. Did any of you contact ODB responsible guys (is it still Roger Chai?) to elucidate that matter ? or Should we try to have Sunnybrook program to broad the criteria of use to fit ODB ones ?

Alice: We have a 3 day supply of Combivir & nelfinavir in all of our ERs for PEP; these supplies are available free of charge to any hospital employee or student. We also make these supplies available for

other people who visit our ER, such as police officers, firefighters, other needlesticks, and so on. I believe the sexual assault centre at Women's also offers PEP to victims, although their first priority is probably trauma counselling and pregnancy prevention.
The matter of how to pay for continued PEP (i.e., the whole 4 weeks) has not actually been that big a deal in most cases. For hospital employees, the drugs are covered by our drug plan, and there is Workmen's Compensation as a backup. In fact, most private plans have covered the month long treatment. It would be great if the Drug Distribution Centre could broaden criteria for use of ARVs for PEP.

Sandy/Marilyn (outpt at Sunnybrook): Sunnybrook has changed it's PEP protocol to include Combivir plus nelfinavir. There are HIV PEP kits in emerg, but to the best of my knowledge they are only used for hospital employees. We have filled many prescriptions for prophylaxis and we always charge and usually the benefit plan of the exposed individual pays for the medication. As a matter of fact we were supposed to use "charge" AZT, not the AZT supplied by the HIV project centre, but with the new guidelines there's no AZT in the regimen. The ODB guidelines (limited use criteria) have not changed to include prophylaxis. In emerg they have a list of 24hr drug stores that patients who have been exposed are encouraged to go to to have their prescription filled.

NNRTI TDM

Kathy: I have a gentleman with Hep C and HIV with poor hepatic function on Sustiva. He is having terrible CNS effects & I suspect that he isn't eliminating it well with his poor liver function (Alice I saw the reference to this from Retr in 99 from your chart that suggests AUC should be the same but...) Anyhow, has anyone gotten TDM done on Sustiva?? If so can you send me the details?

Alice: We haven't done NNRTI levels, but might be set up in the future for this.
Have you seen this article? ..\..\HIV Articles\efavirenz levels.marzolinia.aids01.pdf

Prof. David Back: We are doing TDM of EFV and use a lower cut off of 1200 ng/ml and an upper cut off of 4000 ng/ml. The best, although fairly limited data is from Marzolini et al AIDS 2001; 15: 71-75. showing some relationship between concentration and efficacy/toxicity.

So we have made dose adjustment to 400 od based on CNS effects and high levels. Having said that there are patients who have CNS effects with lower levels so there is certainly not a clear concentration effect relationship.

Immunol

Heather Jarman (Ontario): Our former Director, Janet Gilmour, who is now in Calgary has a patient from Ontario who claims that some friends of his are receiving Immunol IM once monthly for HIV. The only thing that I can find is Tri-Immunol which is DPT but I doubt this is what he is talking about.

Laura Park-Wyllie: I'm not sure what it is... At first I thought it could be Remune (immunogen), but that is usually given every 12 weeks...

Amprenavir liquid

Alice: Does anyone have any suggestions for what to mix with amprenavir liquid to mask the taste?

Marie: had only one patient up to now and he liked the taste!

Natalie: Our kids take it straight. Would something strong-flavoured like grape juice work? If you try it, let me know. Two months later, we are still waiting for ODB schedule 8 approval.

Jeff: got no kids, no adults on liquid.....the bitter/sweetness of chocolate syrup might help!

MAC Treatment without ethambutol

Linda Sulz: We have a non-HIV patient with underlying cancer who has been diagnosed with MAC. She was treated with ethambutol & clarithromycin & subsequently developed a rash over most of her body after 7days of therapy. When stopped, the rash improved. She had taken clarithromycin x 4 courses in the past without event. What are some alternative regimens for treating MAC if a patient has a true ethambutol allergy?

Ann: I know of a number of patients that were in this situation. Most were on rifabutin and one (if I remember correctly) may have been on pyrazinamide. The other option for MAC is ciprofloxacin.

Administration of Inhaled Pentamidine

Linda Sulz: Just wondering what restrictions, if any you have at your institution re: administering this - do you use a negative pressure room? Any special cleaning procedures? We don't use it very frequently, but each time it comes up whether or not to transfer the patient to the 1 or 2 neg pressure rooms in each of our institutions for adminstration. I like to get something in writing, but thought I'd check what others are doing as well. Thanks.

Marie: Until two months ago we had a negative pressure room dedicated to pentamidine administration. Since the demand has decreased dramatically over the years, we had only two patients left to do it at the hospital, it was suggested that they would do it at home. Most others patients have been desensitized to septra whenever possible.

Linda Akagi (BC): We do not use a negative pressure room at our hospital. The pentamidine is administered by a respiratory technician in a well ventilated room (ie windows are left open and the door is closed while the patient is being dosed.) The Respirgard nebulizer has a filter that captures most of the pentamidine that the patient breathes out of their mouth...it just doesn't trap the drug that might come out of their nose. I don't know if this also makes a difference, but we have a number of technicians who administer the pentamidine on a rotating basis and so this also minimizes the technician's total contact time with any pentamidine.

Anita Richard (MB): We have only used the negative pressure room in our Emerg Dept once for a pentamidine inhalation treatment. The room did not exist when pentamidine inhalation was more commonly prescribed. At that time, we used a patient examination room in the Ambulatory Care Facility and scheduled pentamidiine treatments last on a Friday afternoon. The room would then remain closed/unused until Monday. I am told that there were no special cleaning procedures used. I'm afraid we have no written documents related to this matter.

MAC prophylaxis with azithromycin

Jinell: All the recent guidelines suggest Azithromycin 1250mg qweekly for MAC prophylaxis. Does any of you have patients in your clinic on split doses (eg.500mg 3 times/week?) if they cannot tolerate the once weekly? Is there any evidence that you can take azithromycin at split doses for efficacy?

Kathy: We sometimes do this for tolerability, however I don't believe that there is any evidence out there for doing this?? Hopefully it isn't detrimental, it was either this compromise or they wouldn't take it at all in a few cases

Pierre: We have done 250mg po daily 5/7 or occasionally 500mg AM + 750mg HS. I don't think it is evidence-based but it seems to work as well. I favor now the 600mg tablet as it contains less lactose and may be better tolerated. I suggest 1200mg once weekly or alternately 600mg twice weekly.

Linda Akagi: Our guidelines recommend 1200 mg weekly (we use 2 of the 600 mg tablets,also.) If patients have problems tolerating the 1200 mg dose at one go, we have seen patients take 600 mg daily for 2/7. We have maybe 2 patients who take the 250 mg tablets as 500 mg 3 times/week. I have not seen any evidence for the split dose.

Debbie: We also use the 600mg tablets, so if they cannot tolerate 1200mg at once, I suggest splitting the dose to 600 mg bid for one day per week. If this doesn't work, we will usually switch to Biaxin.

Rachel: We also favor 600mg and the most often prescribed dosage is 1200mg once weekly or alternatively 600mg twice on the same day once a week. We have found that the 1200 mg once a week schedule is not well tolerated by a lot of patients. Furthermore we did have some cases (at least 4 recently) of ototoxicity, and we tried to decrease to 500 mg three times a week but the problem persisted. Have you encountered this problem and what did you do. I read this week that INTI could be cause ototoxicity. Have you read this and has it been your experience?

Alice: We generally do the same thing: splitting to 600 mg twice a week or 250 mg 5 times a week to improve tolerability. Despite the lack of evidence, we haven't noticed any problems with efficacy. Re: ototoxicity with azithromycin: we reported a case series a few years ago (CID 1997;24:76-7), where 8/46 patients (17%) who were taking azithromycin 600 mg/day (range 300-1500 mg) developed otoxicity within 30-90 days. One patient also had a positive rechallenge. In all cases, the sx resolved by a mean of 4.9 weeks after azithromycin was stopped.

Tom: We have used once or twice weekly depending on tolerance. Altho' no evidence for split dosing, my guess it should still work given that MAC is intracellular & Azithro has such a long IC-half-life.

Lactic acidosis

Rachel: We recently have had a serious case of lactic acidosis, the patient required admission to the ICU, but he is now home and feeling OK. He received riboflavine, thiamine, l-carnitine and then after 48 hrs of this regimen, dichloroacetate was added - at the time the lactate were already on a downward slope. Dichloroacetate is available as a powder, and it seems to me that the preparation is archaic and not easy to perform in a completely sterile fashion. Do you use this product at all ? and what is your impression on it ?

Linda Akagi: We do not use dichloroacetate at our hospital. There is some theoretical evidence that it may be useful, but I'm not aware that there has been any information which shows that it affects clinical outcome.

Hyperhidrosis

Kathy: Hmm sweating (had to look it up). Anyhow have you guys been seen non-specific excessive sweating in your patients ie no other cause no SSRI, no lymphoma, TSH & temp normal etc. We have had a run on people who are on HAART complaining of this.

Ann: I have seen this for years, even before HAART. It seems to be hit and miss with patients. Never anything that we could tie into but seemed to stay constant (ie. didn't really come and go in an individual patient). It was very troublesome and embarrassing for a few patients. In thinking back, it was more prominent after the initiation of HAART but not exclusive. I can't recall any good treatment for it .

Hope all is well. I am surviving my instant plunge back into acute care medicine. We see a lot of very sick people here as there are no beds to be had in Vancouver to transfer them to quickly. Got paged at 0430 this am re: a methylprednisolone infusion for a head trauma !!!! Who would have thought, a few months ago!!

Debbie: I must admit that I haven't seen a lot of this, however we did have one patient who suffered from hyperhidrosis very badly for several years. He had tried everything -- the prescription deodorant (can't

remember the name), systemic anticholinergics and was even considering botulinum toxin injections! Then I found out about a product from a co-worker (who had a very sweaty sister-in-law), called "Certain Dri" -- it's an antiperspirant from the U.S. It contains Al chloride, Al zirconium, and tetrachlorohydrex glycine, and can be ordered over the internet as it is only avail in the U.S. Apparently you have to use it qhs for a few weeks, then cut back the frequency. I am this patient's favorite pharmacist now since discovering this product. Maybe it's worth checking out!!

New references

New Treatment Guidelines

Adult and Adolescent Guidelines: August 13, 2001 Update Now Available. The updated sections include: Considerations for Initiating Therapy in the Patient With Asymptomatic HIV Infection, Interruption of Antiretroviral Therapy, Table 5, Table 6, and Table 12.
http://www.hivatis.org/guidelines/adult/Aug13_01/text/AAAug13S.PDF

Pediatric Guidelines: August 8, 2001 Update Now Available. Sections that have been updated include: the Treatment Recommendations, Choice of Initial Antiretroviral Therapy, Available Antiretroviral Drugs, Table 8, and the Appendix (Characteristics of Available Antiretroviral Drugs).
http://www.hivatis.org/guidelines/Pediatric/Aug08_01/pedaug08_01.pdf

New HIV postexposure prophylaxis guidelines were published in the June 29, 2001 issue of MMWR (Vol. 50 / No. RR-11). The new recommendations list three optional drug combinations. The guidelines can be found at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm or at http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf

July 2001 DRAFT: 2001 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus.
http://www.hivatis.org/guidelines/OIGuidelinesJuly2001.pdf

TDM

The September supplement of the **British Journal of Clinical Pharmacology (Volume 52, Supplement 1, 2001**) is completely devoted to the topic of therapeutic drug monitoring. The table of contents are:

- Therapeutic drug monitoring: Introduction: *G.M. Shenfield*
- Therapeutic drug monitoring beyond 2000: *G.M. Shenfield*
- Best practice in therapeutic drug monitoring: *A.S. Gross*
- Therapeutic drug monitoring - antiepileptic drugs: *M.J. Eadie*
- Therapeutic drug monitoring: antiarrhythmic drugs: *T.J. Campbell & K.M. Williams*
- The therapeutic monitoring of antimicrobial agents: *E.J. Begg, M.L. Barclay & C.M.J. Kirkpatrick*
- Therapeutic drug monitoring of psychotropic medications: *P.B. Mitchell*
- Target concentration intervention: beyond Y2K: *N.H.G. Holford*
- Immunosuppressant drugs - the role of therapeutic drug monitoring: *A. Johnston & D.W. Holt*
- Therapeutic drug monitoring of cytotoxic drugs: *L. Lennard*
- The role of therapeutic drug monitoring in treatment of HIV infection: *D.J. Back, S.H. Khoo, S.E. Gibbons & C. Merry*
- Therapeutic drug monitoring in drug overdose: *A.H. Dawson & I.M. Whyte*
- Therapeutic drug monitoring in a developing country: an overview: *N.J. Gogtay, N.A. Kshirsagar & S.S. Dalvi*

Montaner J, Hill A, Acosta E. Practical implications for the interpretation of minimum plasma concentration/inhibitory concentration ratios. Lancet 2001;357:1438-40.

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Attachments

- revised CHAP structure & process for membership application
- updated CHAP roster