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HCV Advocate

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What You Need to Know: Liver Biopsy

By Jayna H. Maxwell

A liver biopsy is usually the most specific test to assess the nature and severity of liver disease. In addition, it can be useful in monitoring the efficacy of various treatments. There are currently several methods available for obtaining liver tissue, each with its own advantages and disadvantages.

This article will describe in some detail the percutaneous liver biopsy, the one most commonly used to assess the condition of the liver in hepatitis C patients.

The size of the biopsy specimen, which varies between 1 and 3 centimeters in length and between 1.2 and 2 millimeters in diameter, represents 1/50,000 of the total mass of the liver. Usually, for evaluation of diffuse liver disease (that is, disease which occurs throughout the liver, such as in hepatitis C), a specimen of 1.5 centimeters in length is adequate for a diagnosis to be made.

A liver biopsy can give valuable information regarding staging, prognosis, and management. For example, in patients with chronic hepatitis C infection, not only is there a poor correlation between symptoms or levels of serum alanine aminotransferase (ALT - a liver enzyme which, at elevated levels, is indicative of liver-cell destruction) and histologic features of the liver (that is, whether the tissue and architecture of the liver are intact or damaged), but also patients with completely normal levels of liver enzymes may be found to have clinically significant fibrosis or cirrhosis on biopsy.

If the patient has mild disease and is infected with genotype 1a or 1b of the hepatitis C virus, a decision may be made to defer treatment, since these genotypes are relatively resistant to interferon.

If a decision is made to treat such a patient with a combination of interferon and ribavirin and there are adverse effects, the treatment can be stopped. Conversely, if the patient has moderate-to-advanced disease, treatment will most likely be offered.

If the patient has a virologic response (that is, the viral count decreases markedly) and tolerable side effects with treatment, continued therapy would be strongly encouraged. The finding of cirrhosis on liver biopsy will determine the need for further examinations, such as upper endoscopy to rule out esophageal varices (swollen veins in the esophagus which may hemohorrage) and screening for cancer with blood tests for the presence of alpha-fetoprotein (AFP) and ultrasound of the liver.

In alcoholic liver disease, the severity of the clinical symptoms and the degree of liver-enzyme elevation correlate poorly with the extent of liver damage, particularly in patients who continue to drink alcohol. The long-term prognosis depends on the severity of hepatic, or liver, injury determined upon biopsy. Liver biopsy provides an accurate diagnosis in approximately 90 percent of patients with unexplained abnormalities revealed on liver-function tests.

Percutaneous Liver Biopsy - this type of biopsy is done directly through the skin into the liver. Needles for percutaneous liver biopsy are broadly categorized as suction needles, cutting needles, and spring-loaded cutting needles that have a triggering mechanism. The cutting needles, except for the spring-loaded

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In This Issue:

Nurse Lucy Says Laughter Is Good Medicine

By "I Love Lucy" K. Porter, RN

April Fool's Day originated in 16th century France. The Gregorian calendar was introduced that year, changing the beginning of the year from the end of March to January 1st. Apparently some people celebrated the New Year in March and were referred to as April Fish, later changed to April Fools. As a child, I loved this occasion. I spent weeks dreaming up elaborate pranks, such as gluing pennies to the sidewalk and substituting salt in the sugar bowl.

By permission of Johnny Hart and Creators Syndicate, Inc.

Humor is more than a laughing matter. William Fry, M.D., professor emeritus in psychiatry at Stanford University Medical School, spent much of his career researching the physiological benefits of humor. Fry discovered that laughter changes brain patterns, stimulates the immune system, and reduces stress hormones. Laughter also reduces pain perception.

There have been many books written on the relationship of health and humor. Norman Cousins' descriptions about his two brushes with death are riveting reading. Cousins surrounded himself with humor, convinced of the healing power of laughter. Later, as an advocate of humor, Cousins required his hospital staff to learn and tell a new joke every day.

Humor is all around us. In medicine, there are websites, seminars, the Journal of Jocularity, and an annual conference called the Humor Project. Naturally, humor needs to be used judiciously. There is an appropriate time for laughter, just as there is a time for tears. Only you can be the judge of that. However, if mirth is noticeably absent in your life, you might want to add reading the comics or watching "I Love Lucy" reruns to your health maintenance regimen.

As for hepatitis C, I highly recommend attending a support group. The group I attend always cheers me up. Surrounded by others with the same disease, I believe we feel more relaxed and are more likely to see the humorous side of this challenging condition. Besides, where else can you learn about "Reberettes" - a termed coined by a patient undergoing treatment (a Tourettes-like syndrome induced by Rebetron).

It is my completely unscientific opinion that laughter separates humans from most of the animal world. Perhaps humor is an evolutionary device to help us maintain our physical and mental health. My belief is well summarized by the words of James Thurber, "Humor is a serious thing. I like to think of it as one of our greatest and earliest natural resources which must be preserved at all costs."

HealthWise

Further Information:

Cousins, Norman: Anatomy of an Illness As Perceived by the Patient: Reflections on Healing and Regeneration

Klein, Allen: The Healing Power of Humor

Siegel, Bernie S.: Humor and Healing

http://members.tripod.com/~pattydw/fools.htm

http://www.geocities.com/Athens/Acropolis/1465/april.html

Lucinda K. Porter, RN *is a research nurse and patient educator at Stanford in the area of hepatology. She co-facilitates a support group and is active in many aspects of hepatitis C education. In addition to being HCV positive, she has a life which include her husband and teenaged daughter.*

Ouch! Doctor, It Hurts! The Problem With Pain

by C.D. Mazoff, PhD
Contributing Editor

Last month as I was talking to various support people, a common theme arose: persons suffering from hepatitis C who were in pain were having great difficulty obtaining effective pain medications. I told them I would look into it, and look into it I did. This article is a summary, as it were, of what I found out. And I wasn't ready for what I found. Just for the record, I don't take any pain meds, except for the odd Tylenol now and then, when it gets too bad.

What is pain?

This might seem like a useless question, especially when you're really hurting, but actually it always helps to identify a problem when you're trying to solve it. The International Association for the Study of Pain defines pain as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage." If you ask me that's both broad and vague, but I suppose you have to start somewhere.

Pain occurs when sense receptors called "nociceptors" become stimulated. The nociceptors then transmit information to the spinal cord along different pathways depending on whether the pain is acute or chronic. Messages are sent to the brain which then tries to figure out what to do. Sometimes it can activate certain nerve fibres which will diminish the pain, or release certain neurotransmitters or chemicals, such as enkephalins or endorphins.

Recent studies show that in situations involving infection, inflammation, or peripheral neuropathy, the immune system releases proinflammatory cytokines which create "exaggerated pain as well as an entire constellation of physiological, behavioural, and hormonal changes."1

Other studies show that pain varies from individual, and can be greatly affected by "gender, ethnicity and religion, health care, health status, and emotional distress."2

Treating Pain

There are two broad classes of pain, and both are treated differently.

1. Acute Pain: In acute pain there is apparent organic injury produced by a trauma, such as a burn, or a gunshot wound, or by end stage cancer, for example. Treatment for this type of pain comprises analgesics (from aspirin to opiates), antidepressants, nerve blocks and surgery.

2. Chronic Pain: Chronic pain often has no evident accompanying organic injury, and it is thought by many doctors and scientists that chronic pain, although initially caused by a real injury, is more of a "behaviour state," than a physiological disorder.

The standard approach to treating chronic pain, or "chronic non-malignant pain" (CNP) as it is often called, is to reduce drug dosages, implement alternative modalities, such as physical exercise and meditation, initiate psychological counselling and avoid opiates at all costs.

Current Issues:

A. Medical:

The problem with pain medication other than opiates is mostly due to the side-effects and the fact that they are not very effective.

The most common complication from taking NSAIDS (non-steroidal anti-inflammatory agents) and aspirin, is gastrointestinal bleeding. Obviously those with advanced liver disease and/or bleeding problems cannot take these types of analgesic.

According to the University of Alabama School of Medicine, "although acetaminophen causes less gastric irritation, nephrotoxicity, and antiplatelet activity than aspirin and other NSAIDs, prolonged use may cause hepatotoxicity, especially in patients with liver disease, even at recommended doses. Acetaminophen toxicity occurs in doses of about 4,000 to 5,000 mg per day (equivalent to 8 to 10 Extra Strength Tylenol tablets). The centrally-acting analgesic tramadol (Ultram), which is not chemically related to opiates, may be an alternative for acetaminophen, and can be effective for non-inflammatory pain (headaches, pelvic pain, myofascial disease, fibromyalgia). Side effects include dizziness, nausea, sedation, and constipation, however, tramadol is not associated with GI ulceration or bleeding and does not adversely effect renal function." 3

Then there are opiates and the problem of addiction. Physicians involved in cancer pain management treat thousands of patients with opiates, whose effective analgesia improves overall functioning. The

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Liver Biopsy

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variety, require a longer time in the liver during the biopsy, which may increase the risk of bleeding. A greater incidence of bleeding after biopsy has sometimes been observed with large-diameter needles. If cirrhosis is suspected on clinical grounds, a cutting needle is preferred over a suction needle, since fibrotic tissue tends to fragment with the use of suction needles. This would render the tissue sample less useful or even useless for diagnostic purposes.

Ultrasonography performed before a liver biopsy identifies mass lesions (defined areas of suspicious or diseased tissue) that may not present symptoms and defines the anatomy of the liver and the relative positions of the gallbladder, lungs, and kidneys.

Most hepatologists agree that all patients should undergo ultrasonography of the liver before a percutaneous biopsy is performed. However, it is debatable whether the routine use of ultrasonography to guide the biopsy reduces the rate of complications, provides a higher diagnostic yield, or is cost effective.

It is now standard practice to perform liver biopsy on an outpatient basis, provided that various criteria are met. The Patient Care Committee of the American Gastroenterological Association has published practice guidelines for outpatient liver biopsy. The patient must be able to return to the hospital in which the procedure was performed within 30 minutes after the onset of any adverse symptoms. Reliable persons must stay with the patient during the first night after the biopsy to provide care and transportation, if necessary.

The patient should have no serious medical problems that increase the risk associated with the biopsy. The facility in which the biopsy is performed should have an approved laboratory, a blood-banking unit, an easily accessible inpatient bed, and personnel to monitor the patient for at least 6 hours after the biopsy.

The patient should be hospitalized after the biopsy is performed if there is evidence of bleeding, a bile leak, pneumothorax (air or gas in the pleural space), or other organ puncture, or if the patient's pain requires more than one dose of analgesics in the first 4 hours after the biopsy.

Liver biopsy is a safe procedure when performed by experienced operators. Froehlich et al. noted a lower complication rate for physicians who performed more than 50 biopsies a year. Prior localization of the biopsy site via ultrasound may decrease the rate of complications for physicians who perform liver biopsies infrequently. "Blind" liver biopsies (i.e., without the aid of prior ultrasound localization) should be performed by experienced gastroenterologists, hepatologists, or transplantation surgeons and not by general internists.

Although the liver has a rich vascular supply, complications associated with percutaneous liver biopsy are rare. Sixty percent of complications occur within 2 hours and 96 percent within 24 hours after the procedure.

Approximately 1 to 3 percent of patients requires hospitalization for complications after a liver biopsy,

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The HCV Advocate offers information about various forms of intervention in order to serve our membership at large. By providing information about any form of medication, treatment, therapy or diet we are neither promoting nor recommending use, but simply offering information in the belief that the best decision is an educated one.

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Liver Biopsy *Continued from page 4*

especially if the procedure was performed with a Trucut biopsy needle. Pain and hypotension (dangerously low blood pressure) are the predominant complications for which patients are hospitalized. Minor complications after percutaneous liver biopsy include transient, localized discomfort at the biopsy site; pain requiring analgesia; and mild, transient hypotension. Approximately one-fourth of patients has pain in the right upper quadrant or right shoulder after liver biopsy. The pain is usually dull, mild, and brief.

Ongoing, severe pain in the abdomen should alert the physician to the possibility of a more serious complication, such as bleeding or peritonitis (inflammation of the membrane lining the walls of the abdominal and pelvic cavities).

Although very rare, clinically significant intraperitoneal hemorrhage (bleeding within the membrane surrounding the stomach and pelvis) is the most serious bleeding complication of percutaneous liver biopsy; it usually becomes apparent within the first two to three hours after the procedure.

Risk factors for hemorrhage after liver biopsy are older age, more than 3 passes with the needle during biopsy, and the presence of cirrhosis or liver cancer. The patient may then require intravenous fluids and/or blood products.

The mortality rate among patients after percutaneous liver biopsy is approximately 1 in 10,000 to 1 in 12,000. Mortality is highest among patients who undergo biopsies of malignant lesions. Cirrhosis is another risk factor for fatal bleeding after liver biopsy.

Source Information: From the Liver Center, Division of Gastroenterology, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston

India to Begin Testing Blood Supply for HCV

On June 1, 2001, the Indian government will require mandatory testing of the nation's blood supply for HCV antibodies using imported HCV antibody kits. Currently, the Indian government requires mandatory testing for the hepatitis B surface antigen, HIV, malaria and syphilis.

HCV antibody testing with imported kits presents a big problem in India, because imported kits may not detect genotype 3g— a strain of HCV that accounts for 35% of all HCV infections in that country. A new test has been developed in India for detecting this strain and marketing approval is expected in April 2001.

The World Health Organization estimates that 1.8% of India's population or approximately 17 million people in India are infected with HCV.

Pain

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side effects generally are tolerable, and problems with addiction, infrequent. Many physicians, however, assume that opiates should be used only for chronic malignant pain. Research and clinical experience have demonstrated that opiates can safely and effectively relieve most chronic moderate to severe non-malignant pain. Fears of addiction, disciplinary action, and adverse effects result in ineffective pain management.4

Not all opiates are the same. "Codeine and its equianalgesic analog, dihydrocodeine tartrate, often combined with aspirin or acetaminophen, are the most commonly prescribed opiates for mild-to-moderate pain. Yet, codeine is a poor analgesic, has a ceiling effect, and fraught with side effects," such as vomiting and diarrhea.5 Others, such as morphine and its analogues, although more effective, are generally not prescribed.

B. Ethical:

More and more doctors and nurses are starting to listen to and believe their patients when they tell them that despite trying everything for CNP, they are still in pain.6 Like it or not, the attitude toward persons with CNP has been largely that it is "all in their heads" or mostly in their heads (hence the psychotherapy), and that pleas for stronger medication are really the cries of a weak willed person, or a person likely to become dependant on opiates should they be administered.

In an article in the Journal of Law, Medicine & Ethics, Ann M. Martino argues that the reason many doctors refuse to prescribe opiates is not due to medical fact but rather to an "ethic of underprescribing. Historically many physicians have been at substantial risk of being sanctioned for overprescribing by state medical regulatory boards. Ms. Martino concludes that "fear of regulatory reprisal continues to be the reason physicians most frequently cite for not providing adequate treatment for chronic pain."7

As well, there seems to be a presumption, both on the part of the physicians and the public, that individuals who take opiates for CNP are "addicted." A glance through the medical journals on the problem of CNP and opiates reveals that many persons still question the validity of pain in an individual talking opiates: "A patient with chronic pain who is on multiple medications raises important questions for the case manager. Is the patient's underlying problem actually pain, or is it addiction?"8

What to do?

I'll never forget the day that one of our members came to me and confessed that he felt very guilty about smoking marijuana for his pain and nausea. This person, now cirrhotic and in his sixties, had never taken psychotropic drugs before in his life. The marijuana really helped him. But he couldn't shake the guilt.

Another member, who takes methadone to help cope with the pain from a severe spinal injury, runs the risk of being disqualified for a liver transplant since the question of addiction is always in the shadows.

Yet another member who has advanced liver disease, had her kidneys ruined by interferon. She is in pain from this and from arthritis. She was prescribed ibuprofen (Advil) and began to experience serious pain in her liver. Some persons are prescribed amitriptyline for fibromyalgic pain, despite the fact that it is bad for the liver.

Add to this the fact that many persons with hepatitis C are past or present IDUs, I can understand how doctors can be hesistant to prescribe pain medication. But the fact remains that whether or not one is or has been an addict, pain is pain, and it should be treated if the patient so requires.

Perhaps the answer to this difficult question lies not so much in research laboratories, but in the office of your local GP. How many doctors nowadays take the time to get to know each of their patients? How many of them really take the time to listen to our experience, and encourage a cooperative approach to health management.

Maybe if physicians would know their patients better, this would enable them to make the right choices. "To do no harm"...works both ways. Making the decision to treat or not to treat takes time.

11Watkins, LR, Maier SF. The Pain of Being Sick: implications of immune-to-brain communication for understanding pain. Annual Review of Psychology 2000;51:29-57.

2 Rotheram-Borus, MJ. Variations in perceived pain associated with emotional distress and social identity in

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News Briefs

HCV Viral Loads in People Coinfected with HIV and Hep C

The February issue of the Journal of Medical Virology reported a study by Rey D, et al that found significant amounts of HCV RNA in individuals coinfected with HIV and hepatitis C.

Fifty-nine individuals with HIV and hepatitis C were tested for HCV viral levels from paired blood and saliva samples to examine the amount of detectible HCV present in the saliva of this group. Nested-PCR was used to detect possible HCV RNA and confirmed with a b-DNA analysis.

The researchers found that 22 out of the 59 individuals (37.3%) of the patients had detectable levels of HCV RNA in their saliva. The mean level of HCV RNA was 1.15 Million-genome equivalent per milliliter. There was no correlation of salivary positivity with CD4 cell count, HIV risk group or age, but there was a correlation with gender - males (50%) vs. female (14.3%).

This is the first study to report significant amounts of HCV RNA in saliva and deserves further investigation. The study did not look at transmission of HCV by saliva.

Source: J Med Virol 2001 Feb:63(2): 117-119

Psychiatric Conditions Influence the Outcome of Interferon-alpha Treatment for Hepatitis C

Veterans with chronic hepatitis C and psychiatric diagnoses experienced a significantly greater number of major adverse side-effects during interferon-alpha treatment, according to a report in January's American Journal of Gastroenterology.

A team from Minneapolis, Minnesota analyzed the effect of pre-existing psychiatric conditions in veteran patients undergoing interferon-alpha (IFN-alpha) treatment, with respect to adverse events, compliance, and treatment response.

Thirty-three veterans with chronic hepatitis C were treated with IFN-alpha (5 million units three times weekly) for 6 months, followed by a tapering dose for an additional 6 months.

The researchers from the Veterans Affairs Medical Center and the University of Minnesota examined psychiatric diagnoses, adverse events, and virological and biochemical responses to therapy.

Fifty-eight percent of the patients with hepatitis C had documented psychiatric conditions before starting IFN-alpha therapy.

Of the patients with pre-existing psychiatric diagnoses, 68% developed major adverse events requiring intervention or discontinuation of therapy.

In contrast, only 29% of patients without psychiatric diagnoses developed major adverse events.

The proportion of patients who developed major neuropsychiatric side-effects were as follows:

* Psychiatric 32%
* Non-psychiatric 14%

In the psychiatric group, 32% developed major neuropsychiatric side-effects compared with 14% of patients in the non-psychiatric group.

Patients with and without psychiatric diagnoses had equivalent biochemical and virological responses to therapy. Overall, only 6% of all patients had a sustained virological response.

Researcher S. B. Ho said on behalf of the group, "Veterans with chronic hepatitis C and psychiatric diagnoses experienced a significantly greater number of major adverse events during treatment with IFN-alpha."

"Veteran patients with hepatitis C should be carefully screened for psychiatric conditions and may require more intensive monitoring during IFN-alpha therapy," it was concluded.

In an accompanying editorial, Ramsey Cheung and Aijaz Ahmed commented, "The small sample size and vast heterogeneity of psychiatric disorders among the patients in this study make it difficult to extrapolate recommendations for HCV therapy in patients with psychiatric disorders."

"However, patients with pre-existing psychiatric disorders require closer follow-up than the average patient while receiving antiviral therapy," they concluded.

Source: January 2001, American Journal of Gastroenterology.

ANKORS AWAY!: An Upclose Look at a Rural Needle Exchange Program in British Columbia

By Ken Thomson
Hepatitis C Support and Education
Project Coordinator, ANKORS

Blinding snow, shoulders knotted from the tension of trying to steer ever so gently down a sloped, winding, skating rink between towering rock faces with signs stating "Do Not Stop - Avalanche Area" and the precipitous drop -off just barely visible beyond the overworked wipers. That's the Mobile Needle Exchange - Kootenay style.

Of course, the summers are a different story. A more beautiful office doesn't exist; a fact not lost on the hordes of RVers leading long lines of exasperated local drivers who think back wistfully to the desolate highways of winter.

17,000 square miles of mountainous terrain make up the territory covered by the Mobile Needle Exchange operated by ANKORS in the southern interior of British Columbia. Its an area dotted by small towns and rural mountain hideaways populated by aging hippies, loggers and an assortment of people drawn by the beauty, low cost of living and apparent anonymity.

Apparent, because gossip, as in small towns everywhere, is the next best thing to satellite TV. It's a double edged sword, making confidentiality more difficult than in big urban centers, while at the same time, small town intravenenous drug users are more likely to keep an eye out for their peers. To protect people's privacy, the exchange often comes right to their homes.

Like its city cousins, the ANKORS Needle Exchange is about reducing the spread of HCV and HIV as well as harm reduction for intravenous drug users, their loved ones and the entire community. Sterile syringes, dental cottons and information about vein care and safer injecting are all part of the service that's designed to reduce transmission and to assist those already infected to stay as healthy as possible.

The exchange rate is over 112%, reflecting the concern that users have for their own and the community's health, new contacts and a small number of IVDU's who are also diabetics.

Many injection drug users have other issues to address. They may need to access health, social and other frontline services. Developing a respectful and trustworthy relationship, providing support, transportation and advocacy are cornerstones of this work.

"Lack of access to clinical trials, specialists and the judgemental attitudes of some of the medical profession coupled with a lack of experience in dealing with patients in this situation are barriers to health in rural areas."

When he's not on the streets or dealing with the four fixed exchange sites, Alex Sherstobitoff, the Needle Exchange Coordinator, is in the bars and coffee shops making his presence known and quietly educating staff and patrons alike, about everything from safer sex to dealing with blood spills. "Patience, trust and good information are probably the most important things" states Sherstobitoff.

Homelessness has a different face here. Weather and geography make "couch surfing" and trading sex for food, drugs or shelter the alternative to being on the street. Twenty below, four feet of snow and a street that's only three blocks long is a tough go.

Lack of access to clinical trials, specialists and the judgemental attitudes of some of the medical profession coupled with a lack of experience in dealing with patients in this situation are barriers to health in rural areas.

In collaboration with other community organizations, ANKORS has established Community Care Teams to help meet the needs of those people infected with HCV and HIV.

Because we don't live in a vacuum, education of health care, frontline service providers and the community at large is very important. When its done well, barely conscious prejudices and assumptions are replaced by accurate information and understanding.

The Needle Exchange involves a lot of hard work and travel, but when you live in a small community you realize that there is no "us and them". We are all in this together.

Support Groups

Northern California

San Rafael
Barry Howe (415) 453-3622

Redwood City
For Info Call: (650) 367-5998

San Francisco (2)
(1) Drop-in Support Group / (2) Hep C 101
For Info Call: CHRC (415) 923-3155

San Mateo
Debra Magnum (650) 581-3339

San Jose
Susi Nelson (408) 734-3516

Sacramento
(916) 491-4942

Sunnyvale
Craig Miller (408) 734-3516

Santa Rosa
(707) 544-3295 ext.14

Newark
(510) 792-4357

Santa Cruz
HCV Healing Circle
Bev Davis: (831) 462-1481

Monterey
Cyndra Horton (831) 883-0711

Vallejo
Sue Simon (707) 647-0854

Southern California Resource Line

Call for hepatitis information and support.

1-888-85LIVER

Support Groups

Southern/Central California

Orange County
Carol Craig (949) 654-42508

Long Beach
Carol Craig (949) 654-4250

Santa Barbara
[redacted]

Santa Maria
[redacted]

Ojai
[redacted]

Pain

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AIDS. AIDS Patient Care STDS 2000 Dec:14(12): 659-65

3 Opiates for Chronic Nonmalignant Pain: A Primary Care Approach for Geriatrics. CME Online, Jan 18 2000.

4 Steven D. Passik, Ph.D., Herman J. Weinreb, M.D. Managing Chronic Nonmalignant Pain: Overcoming Obstacles to the Use of Opiates. Advances in Therapy 2000 Mar-Apr:17(2):70-83.

5 Opiates for Chronic Nonmalignant Pain: A Primary Care Approach for Geriatrics. CME Online, Jan 18 2000

6 Hunter, S. Determination of moral negligence in the context of the undermedication of pain by nurses. Nursing Ethics 2000 Sep;7(5):379-91.

7 Ann M. Martino, "In Search of a New Ethic for Treating Patients with Chronic Pain: What Can Medical Boards Do?" Journal of Law, Medicine & Ethics, 26, no. 4 (1998): 332-49.

8 Schneider, JP. Chronic Pain Management: evaluating the use of opiates. Case Manager 1999 May-Jun;10(3):61-6.

Northern California Helpline

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Leave a message and a volunteer will return your call within 24 hours.

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Clinical Trials

Northern California

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Linda Brooks (415) 202-1504 or (415) 202-1506
San Francisco General Hospital
Athiana (415) 206-3725
Stanford University Hospital
Stanford Liver Research Clinic (650) 724-7057
Quest Medical Research
Dr. Jay Lalezari (HIV/HCV Co-infection trials)
(415) 353-0800
East Bay Liver Clinic
Oakland, CA 94609
Contact: Grant Young - 510/208-1777

Dr. John J. Jolley - San Rafael
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Monday, Tuesday, & Wednesday
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UC Irvine Medical Center
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