

I T N S

GOLDEN TRIANGLE Chapter

Newsletter



Editor: Christine Shay

Winter 2004

President's Message by **Christine Shay, RN, BSN, CCTC**

Now that the New Year is well underway and the excitement and craziness of the holidays has passed, it's time to get back to business. Your GTC Board of Directors has continued to meet on a monthly basis and is making leaps and bounds towards promoting membership growth and development. Not only will the wonderfully planned quarterly dinner meetings and journal clubs continue, but your Board would like the GTC of ITNS to grow in number and be seen and recognized in the public eye.

There are a wide range of ideas and a variety of activities in the works. Sponsoring events such as the Transplant Olympics financially, registering attendees at local educational dinners affiliated with transplantation, and staffing ITNS exhibits at local conferences are just to name a few. Our next journal club in March will be via video-conference so as to include our sister transplant team at Ismett in Palermo, Italy. Branching out to invite other local chapters to our 4th Annual Collaborative Approach to Transplant this fall is exciting as well. The GTC Newsletter is also growing and expanding exponentially to include many new ideas and information helpful to the transplant population.

There is, however, one kink in this plan. Your Board of Directors cannot do this without you. The membership of the GTC of ITNS is diverse and strong with endless opportunity to work collaboratively as a multidisciplinary team. There is also a plethora of avenues for networking. We have matured as a membership over the years. It is only to be expected that as we continue to grow and mature as a membership, we will empower ourselves to give more to others...just as we need to mature within ourselves personally before we can give to others on a personal level.

Your Board of Directors thanks you in advance for accepting a challenge to be placed in front of you. Each and every one of you is being challenged to participate in one chapter activity or serve on one chapter committee this year. When you think about the diversity of our chapter membership, your participation in just one of these activities will contribute to the growth and development of the GTC of ITNS. At the same time, this growth will be visible outside the confines of our dinner meetings and journal clubs. After all, why shouldn't the public know about ITNS?? We are a growing, professional, down right awesome organization !!!

**THIRD ANNUAL COLLABORATIVE APPROACH TO TRANSPLANTATION
SEPTEMBER 18, 2003
ALLEGHENY GENERAL HOSPITAL, PITTSBURGH, PA**

The Third Annual Collaborative Approach to Transplantation was held on September 18, 2003 at Allegheny General Hospital. It is the first collaboration between two nursing organizations to provide yearly educational activity. The Golden Triangle Chapter, International Transplant Nurses Society (ITNS) and the North American Transplant Coordinators Organization (NATCO) are proud to have organized this conference for three years and plan to continue this tradition in the future. This conference started with a keynote panel of physicians discussing the use of an expanded donor pool in organ transplantation. This was followed by updates regarding current immunosuppressive regimens. The morning concluded with a presentation of various organ-specific case studies. Current management of Hepatitis C in the post transplant population and the latest updates on living donor issues were also discussed. Concurrent sessions were offered during the afternoon and were specific to either the hospital/bedside nurse track or the clinical coordinator track. We would like to thank all planning committee members, speakers, moderators, sponsors, and attendees for their time and investment in this successful conference. The success of this type of event is owed to all of you!!

**UNOS REGION II FORUM
SEPTEMBER 25, 2003
AIRPORT WYNDHAM, PITTSBURGH, PA**

The UNOS Region II Forum was held on Thursday, September 25, 2003 at the Airport Wyndham. All who attended enjoyed a day full of informative speakers. Lectures began with a variety of topics covering new technologies for pre and post transplantation and developments in minimization of immunosuppression. Financial incentives for organ donation and differences in grief responses between organ and tissue donor families were also discussed. An evening reception was held at the Hyeholde restaurant in Pittsburgh and the speaker was Dr. Paulo Fontes, Co-Director of Liver Transplantation at UPMC. He spoke about issues related to use of an expanded donor pool for liver transplantation.

**12TH ANNUAL ITNS SYMPOSIUM
TRANSPLANT NURSING: REFLECTIONS, REALTY & RESEARCH
OCTOBER 2-4, 2003
DOUBLETREE RESORT, PARADISE VALLEY, SCOTTSDALE, ARIZONA**

Transplant Nursing: Reflections, Reality, & Research, the 12th Annual ITNS Symposium, was held October 2-4 2003 at the Doubletree Resort at Paradise Valley in Scottsdale, Arizona. The first of this three day symposium offered a variety of workshops ranging from Transplant Nursing 101 to Improving your program through education & measuring outcomes. The 2nd & 3rd days included lectures by informative speakers on issues such as the evolution of transplant nursing, quality of life, live organ donation, and many others. The afternoons were full of concurrent sessions related to numerous organ specific issues. The educational component as well as the networking opportunities during this conference were beneficial and endless. We look forward to the conference next year in Vancouver and encourage all to attend.

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PROFILES IN TRANSPLANT NURSING

by

Mimi Funovits, RN, BS, CCTC

We are excited to present to you a new series of articles that you will find in each edition of our chapter newsletter. Beginning with this edition, we will profile a Golden Triangle Chapter member. We could not imagine a more deserving ITNS member to profile for our first series than our very own **KANDY YARRIS NEWELL, CO-FOUNDER of ITNS**.

I had the pleasure to sit down with Kandy for a few minutes to determine exactly how and why she started ITNS and how she feels about the organization 11 years later. Kandy is not only a visionary, but is also known by her colleagues, patients and families as a stronghold for Transplant Nursing. She has a calm reassuring voice which speaks with knowledge and a deep commitment to patients and to her transplant colleagues.

Kandy attended Edinboro University and graduated with a BSN in 1985. She became interested in transplant nursing when she interned on a transplant unit in 1984. Her first nursing position was a staff nurse on the Kidney Transplant Unit at the University of Pittsburgh Medical Center (UPMC) from 1985 through 1990. She had also worked for the Outreach program for Referral Communications and as a nurse recruiter at UPMC while still working on a transplant unit. Kandy became a Clinical Transplant Coordinator for the Thomas E. Starzl Transplantation Institute of UPMC in 1991 and still works as a coordinator there today.

Kandy became interested in joining The American Nephrology Nurses Association (ANNA) in 1990. She thought, "Wouldn't it be neat to have a special interest group for *all* transplant nurses". Kandy's supervisor introduced her to Nancy Stitt, another nurse within the UPMC family. They thought they might create a Transplant Nursing newsletter for all transplant units of UPMC. Together they met with a co-founder of The National Flight Nurses Association, Ford Keyes. Ford encouraged them to broaden their vision and set their sights not locally, or even nationally, but to go international!

Kandy's vision was to "gather colleagues together who have a uniqueness of circumstances in Transplant Nursing to provide methods of communication, research opportunities and solutions to problem-solving in order to better care for our patients". She has always tried to gear the organization to the nurse who provides bedside care believing that they have unique issues in caring for transplant patients. She certainly accomplished this goal and admits that she saw the fruition of their hard work when more than 300 transplant professionals attended the first International Transplant Nurses Symposium in a blinding snowstorm in Pittsburgh.

When asked what she thinks of the organization now and how far we have come, Kandy says she is thrilled. She is excited to see ITNS still thriving and growing with more than 1,100 members worldwide. She is pleased that the development of the staff nurse certification exam is underway, and that dissemination of transplant nursing research occurs with more ease because of ITNS. When Kandy is not working, or at home with husband John and their daughters Molly (age 7) and Megan (age 5), she enjoys photography, gardening and cooking. Kandy is an accomplished photographer and has exhibited locally. Our hats off to you Kandy! We are very fortunate to have you in our ITNS chapter and it's all because of your dreams and determination. We've come a long way baby!

UPCOMING EVENTS

January Dinner Meeting

Date: Wednesday, January 21, 2004
Location: Wyndham Garden, Oakland
Sponsor: Marilyn Bartucci, Fujisawa
Speaker: Robert Kormos, MD
Topic: New Options for End Stage CHF

April Dinner Meeting

Date: To be announced
Sponsor: Dan Foust, Roche

Journal Club

Date: Wednesday, March 17, 2004
Host: Post-Operative Liver Service
Sponsor: Dan Foust, Roche
Location: To Be Announced

Details regarding these events may be accessed on the GTC voicemail at 412-648-1139.

GTC NEWS

Congratulations to the following Transplant Coordinators on passing their CCTC Exams:

- ❖ Peggy Higby, RN, BSN, CCTC
- ❖ Janice Glidewell, RN, BSN, CCTC
- ❖ Tammy Tokarczyk, RN, BSN, CCTC
- ❖ Mary Beth Lewis, RN, CCTC

Welcome to the following new members of the Golden Triangle Chapter, ITNS

- ❖ Patricia Harris, Children's Hospital
- ❖ Kimberly Meyer, Renal Transplant Coordinator, UPMC
- ❖ MaryAnn Palumbi, Senior Director, Transplantation Services, AGH
- ❖ Ruth Tarantine, Clinician, Unit 12N, UPMC
- ❖ Nance Conney, Operations Manager, Starzl Transplant Institute
- ❖ Kathleen Dalesandro, Clinician, Unit 12N, UPMC
- ❖ Chavonne Newman, Staff Nurse, Unit 12N, UPMC
- ❖ Christina Mascara, Staff Nurse, Unit 12N, UPMC
- ❖ Diane Jaynes, Staff Nurse, Unit 12N, UPMC
- ❖ Ann Lee, Post-Lung Transplant Coordinator, UPMC
- ❖ Jackie Spangler, Post-Lung Transplant Coordinator, UPMC
- ❖ Darlene Koritsky, Clinical Research Coordinator, IRTC

Congratulations to Shelley Zomak who has been appointed to the ABTC Clinical Exam Committee.

BOARD OF DIRECTORS

President: Chris Shay, RN, BSN, CCTC
President-Elect: Mimi Funovits, RN, BSN, CCTC
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MS, CCTC
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Secretary: Kathy Henderson, RN, BSN

ITNS
GOLDEN TRIANGLE CHAPTER

Journal Club Summary

DATE: December 15, 2003

TOPIC: HIPAA Concerns and Issues

ARTICLES:

1. The New HIPAA Medical Privacy Rule: Help or Hindrance for Clinical Research?
2. The HIPAA Privacy Rule and its Impact on Pediatric Research
3. Legal Concerns Surrounding E-mail Use in a Medical Practice

PRESENTERS:

1. Debra Mayher RN, MS, CCTC, Clinical Research Coordinator, TESTI
2. Holly Chapman RN, Clinical Research Coordinator, TESTI
3. Cathy Casinelli RN, BSN, Primary Nurse, Unit 7F

SPONSOR:

Genzyme (Formerly Sangstat)
Sharon Kippenberger, RN, MSN, MBA

ATTENDANTS:

34 Clinicians, Researchers, Coordinators, Clerical Staff

SUMMARY:

The **first article** outlined that prior to HIPAA, the FDA and Institutional Review Boards insured privacy and confidentiality under the "Common Rule". Critics argued that IRBs were usually unable to accomplish this secondary to overwork and lack of expertise. In addition, there were concerns that commercial sponsors would use studies as a marketing tool. As a result, the Standards for Privacy or Individual Health Information, under HIPAA was drafted in 1996 to address these concerns. After undergoing modifications, this took effect in April of 2003.

Due to technicalities in the statutory design of HIPAA, restrictions have been placed on researchers regarding the collection of information from patient medical records and how it may be used. Previously acceptable de-identified data no longer meets the more stringent approval criteria. This causes great difficulty for researchers needing data such as zip codes or birth dates in their studies. Thus, new consents with much more intensive and detailed language, as well as more stringent review processes must be developed to insure compliance with data collection.

The end result is that research has been encumbered due to overly detailed consent forms and explanations as to how all safeguards required by the new law will be enforced and implemented. The authors believe this will become a major impediment to research. The new policy will be a hindrance to future progress in research.

The **second article** again outlined that IRBs have evaluated an investigator's plan for protecting the privacy of subjects and their data. The Department of Health and Human Services have published guidelines, "Protecting Personnel Health Information in Research: Understanding the HIPAA Privacy Rule". Now that HIPAA regulations have been implemented, an additional layer of privacy protection exists for human research subjects.

Several approaches can be utilized in order to obtain consent. The most commonly used is to obtain a Privacy Rule authorization. An authorization is a subject's or parent's permission to collect, use, and disclose PHI. Under certain circumstances, the IRB may issue a waiver of authorization. A waiver determines that the risk to privacy incurred in a research study is so minimal that the PHI can be used without the subject's permission. The category *activities preparatory to research* allows a researcher to conduct a preliminary review of charts and records with the understanding that no data will leave the institution. Research on decedents allows a researcher to conduct research on the deceased without obtaining authorization from the next of kin. Participation in disease registries may occur without an authorization or waiver if the data conform to the Privacy Rules definition of a *limited data set* and a signed Data Use Agreement is executed. So despite all the initial consternation regarding HIPAA and research, it seems that research continues, yet a little more carefully.

The **last article** outlined legalities surrounding the use of email in a medical practice. The authors agreed email could be useful when utilized appropriately. First, a medical professional can use email to consult with another colleague about a patient or certain subject matters. Second, medical professionals may use email to communicate to their patients. Other medically related uses of email for patients include requesting prescription refills, making appointments, and securing answers for billing questions. Email does not require both parties to be available at the same time. Email eliminates phone tag and it also permits the patient to dial directly with their practitioner instead of an intermediary. Email also provides a hard copy of exactly what was discussed, which can be placed in the patient's medical record.

Email does have its limitations. It can not be used in case of urgent matters. Another downside is that email is transmitted in a neutral tone, thus the tone of the patients and professionals are not expressed. Practitioners may also become overwhelmed if patients abuse the ease of contact by emailing numerous messages. Practitioner responses to each email may be time consuming when coupled with their other duties.

Stimulating dialogue resulted following the journal article presentations. Much of the discussion was focused on email use within the hospital and clinic settings. The majority of services stipulated that their patients are requested to sign the "Patient Consent for Health Information to be Communicated by E-Mail" under policy HS-IS0147. Guidelines from the UPMC Policy and Procedures Manual for the use of electronic mail and messaging were also discussed.

ON THE LIGHTER SIDE. . . .

Top Ten Reasons to Work an Overtime Shift on the Weekend

10. Think of all the weight you'll lose from not getting to eat because of short staffing.
9. Think of the closeness you'll develop with your co-workers after being knee-deep in Code 10's, Code Blues and Code Browns.
8. Everyone is so frazzled, so next to them you look fabulous!
7. Think of what a challenge it will be to your nursing skills to run a Code without a Crash Cart because they are all down in Central Supply being replaced.
6. The joy of having the previous shift's charge nurse tell you, "I don't understand why no one would return my calls to work today or tonight. Oh, and by the way, you have four nurses for this shift, and a full house of patients sick as dog dirt."
5. Because you're a new grad and you want to be a "TEAM PLAYER" like your head nurse told you to be. (That and you have "sucker" stamped on your forehead!)
4. When you go home with your back aching from not having any nursing assistants who work weekends and your feet aching from running your butt off for "emergency procedures" (like the gas pain your patient has had for a week that is suddenly unbearable), you'll know that you really ARE a caregiver.
3. Think of all the computer skills you'll gain from putting in your own orders and ordering supplies from Central Supply. (That can go on your resume as.... "Know how to operated multiple outdated computer equipment.")
2. You don't have time to adequately chart so you may get to learn how our judicial system works. On the bright side, your handwriting will be so bad that it can say whatever you want it to say!
1. Think of what a GREAT "Learning Experience" this will be. (Translation: You just got shafted!!)

An elderly patient needed a heart transplant and discussed his options with his doctor. The doctor said, "We have three possible donors; tell me which one you want to use. One is a young, healthy athlete who died in an automobile accident. The second is a middle-aged businessman who never drank or smoked and who died in his private plane. The third is an attorney who just died after practicing law for 30 years." "I'll take the lawyer's heart," said the patient. After a successful transplant, the doctor asked the patient why he had chosen the donor he did. "It was easy," the patient replied. "I wanted a heart that hadn't been used."

The patient demanded, "Doc, I need a liver transplant, a kidney transplant, a cornea transplant, a lung transplant, and a heart transplant." "WHAT?" yelled the doctor. "Tell me, exactly why you think you need all these transplants." "Well," explained the patient, "my boss told me that I needed to get reorganized."

A new arrival, about to enter hospital, saw two white coated doctors searching through the flower beds. "Excuse me," he said, "have you lost something?" "No," replied one of the doctors. "We're doing a heart transplant for an IRS agent and want to find a suitable rock."

"Are you an organ donor?" "No, but I once gave an old piano to the Salvation Army."

Pegylated Interferons for the Treatment of Chronic Hepatitis C

Rebecca L. Corey, Pharm.D., BCPS

Clinical Pharmacist - Liver Transplantation, Thomas E. Starzl Transplantation Institute
Assistant Professor, University of Pittsburgh School of Pharmacy

Presently in the United States, hepatitis C virus (HCV) is the most common chronic blood-borne infection and HCV related liver disease remains the leading indication for liver transplantation. Over the last several years, HCV treatment has evolved from administration of standard interferon (IFN) to a combination of IFN plus ribavirin (RBV) and finally to the current treatment of choice: combination therapy with pegylated interferon (PEG-IFN) plus RBV.

Two pegylated interferons have been approved by the United States Food and Drug Administration (FDA) for treatment of interferon naïve adults with chronic HCV (CHC) infection and compensated liver disease. Peginterferon alfa-2b (PEG-IFN2b) [Peg-Intron,[®]Schering-Plough] is approved as monotherapy (January 2001) and as combination therapy (August 2001) with RBV capsules (Rebetol,[®]Schering-Plough). Peginterferon alfa-2a (PEG-IFN2a) [Pegasys,[®]Hoffman-LaRoche] is approved as monotherapy (October 2002) and as combination therapy (December 2002) with RBV tablets (Copegus,[®]Hoffman-LaRoche). More recently, a pre-filled pen delivery system (Peg-Intron Redipen[™]) was approved (October 2003) for reconstitution and administration of PEG-IFN2b powder for injection. The Redipen[™] is expected to become available in early 2004. A pre-filled, ready-to-administer syringe (Pegasys[®] pre-filled syringe) for PEG-IFN2a was approved and should also be available in January, 2004. In addition, on January 20, 2004, Schering-Plough announced approval of a new, bubble-gum flavored oral RBV solution (Rebetol[®]) for combination therapy with IFN (Intron A[®]) in pediatric patients with CHC.

Pegylation refers to the process of attaching a polyethylene glycol (PEG) molecule to a protein drug molecule such as IFN. Attachment of PEG in either a branched or linear structure creates a shield around the IFN and protects it from renal clearance, enzymatic degradation and recognition by cells of the immune system. The primary advantages of PEG-IFN when compared to standard IFN include: a longer half-life and therefore less frequent administration (once weekly for PEG-IFN versus three times weekly for IFN), improved therapeutic efficacy and improved tolerability due to more sustained absorption and smaller fluctuations in plasma concentrations.

When compared to IFN based treatment regimens, PEG-IFN based treatment regimens result in higher sustained virologic response rates (SVRs), defined as clearance of detectable virus (HCV RNA) at the end of treatment and continued undetectable HCV RNA for six months after completion of therapy. For example, when used as monotherapy, overall SVRs of ~25-39% can be achieved with the PEG-IFNs compared to <20% with IFN monotherapy. In addition, patients who successfully complete 48 weeks of combination therapy with PEG-IFN plus RBV can achieve overall SVRs between ~54-61% (versus ~44-47% with IFN+RBV). Furthermore, patients infected with HCV genotype 1, a genotype that is less responsive to treatment, can achieve SVRs of ~42-51% with PEG-IFN plus RBV (versus ~33-36% with IFN+RBV). Patients infected with HCV genotype 2 or 3 generally respond better to treatment and this patient population has achieved SVRs of ~70-80% with 24 and 48 week combination treatment durations producing similar responses. Of note, treatment with RBV alone does not result in clearance of HCV; therefore this antiviral agent should not be used as monotherapy.

The most common adverse effects observed with IFN and PEG-IFN therapy include flu-like symptoms (fever, headache, myalgia, fatigue), hematologic abnormalities (neutropenia, thrombocytopenia) and neuropsychiatric disorders (depression, anxiety), as well as injection site reactions, diarrhea, nausea, insomnia, alopecia, pruritis, anorexia, etc. Other less common, but serious adverse effects have been

observed, including: severe psychiatric (e.g. suicidal ideation), cardiovascular (e.g. myocardial infarction), endocrine (e.g. thyroid dysfunction, diabetes mellitus), autoimmune (e.g. psoriasis, lupus), pulmonary and ophthalmologic disorders as well as pancreatitis, colitis and serious infections. The most common adverse effect of RBV is hemolytic anemia, which can be particularly problematic in patients with heart disease. Anemia secondary to RBV is more common if the drug is used or if the dose is not reduced appropriately in patients with renal insufficiency. Combination therapy (PEG-IFN+RBV) is contraindicated in patients with hypersensitivity, autoimmune hepatitis, decompensated liver disease, hemoglobinopathies (e.g. sickle-cell anemia), neonates or infants, pregnant females and males with pregnant female partners. Extreme care must be taken to avoid pregnancy; at least two reliable forms of effective contraception must be utilized during combination therapy and for at least 6 months afterward. In general, the overall adverse effect profile of PEG-IFN is similar to IFN. However, flu-like symptoms tend to be less severe and neutropenia more common in PEG-IFN treated patients. During treatment with PEG-IFN and RBV, patients usually require granulocyte colony stimulating factors (Neupogen[®]) and erythropoietin (Procrit[®], Epogen[®]) or darbepoetin (Aranesp[®]) to manage neutropenia and anemia, respectively.

COMBINATION ANTIVIRAL THERAPY FOR HCV			
DRUG	Peginterferon alfa-2a	Peginterferon alfa-2b	Ribavirin
BRAND NAME	Pegasys [®] Pegasys [®] pre-filled syringe	Peg-Intron [®] Peg-Intron Redipen [™]	Copegus [®] Rebetol [®]
PEG	40 kDa, branched	12 kDa, linear	---
USUAL DOSE ¹	180 mcg	Monotherapy: 1 mcg/kg Combination: 1.5 mcg/kg	800-1200 mg/day
ROUTE	Subcutaneous injection	Subcutaneous injection	Oral
FREQUENCY	Once weekly	Once weekly	Daily in 2 divided doses
DURATION ²	Variable (~24-48 weeks)	Variable (~24-48 weeks)	Variable (~24-48 weeks)
AVAILABILITY	180 mcg/ml premixed, single- dose vial 180 mcg/0.5ml pre-filled single-dose syringes	50 mcg/0.5ml* 80 mcg/0.5ml* 120 mcg/0.5ml* 150 mcg/0.5ml* single-dose vials containing powder for reconstitution Redipen [™] also in 50, 80,120,150 mcg strengths* *includes diluent (SWFI) ³ for reconstitution of powder	Copegus [®] 200 mg tablet Rebetol [®] 200 mg capsule Oral solution

¹Lower initial doses, dosage reductions, or discontinuation of therapy may be required in patients who develop renal insufficiency or in patients who are experiencing toxicity. ²Recommended duration of combination therapy: 48 weeks for HCV genotype 1 or 4, 24 weeks for HCV genotype 2 or 3. Treatment discontinuation should be considered for patients who have not achieved a virologic response (> 2 log ↓ in HCV RNA) after 24 weeks of treatment. ³SWFI = Sterile water for injection.

Although the incidence of HCV infection has declined since HCV blood screening tests became available in 1992, the prevalence of chronically infected individuals has increased. As a result, the number of individuals with end-stage liver disease and hepatocellular carcinoma is rising and the number of HCV related liver disease deaths is expected to increase at least 2-fold during the next decade. Fortunately, the most recent advancement in chronic HCV treatment, pegylation of IFN, has resulted in agents with improved efficacy, improved tolerability and pharmacokinetic profiles that allow more convenient, once-weekly dosing schedules. Nevertheless, chronic HCV infection still remains an epidemic and with almost universal recurrence after liver transplantation, HCV infection will continue to be a challenge. Hopefully, additional clinical experience and results of clinical trials will provide more information regarding treatment of patients with moderate to severe decompensated cirrhosis, relapsers, non-responders, patients with advanced liver disease (cirrhosis or bridging fibrosis) and patients with recurrent HCV after liver transplantation. Close clinical and laboratory monitoring of patients during antiviral therapy and counseling regarding adverse effects, proper administration technique, and the importance of compliance is essential in order to promote optimal drug therapy outcomes in HCV infected patients.

Announcements

- ❖ **GTC membership renewal** is due in the Month of October. Members submitting renewal dues by October 31, 2003 will be entered into a drawing. Winner to be announced at January Dinner Meeting.
- ❖ Annual **Membership Drive** will run from January 1, 2004 to June 30, 2004. The GTC member to sponsor the most new members after a minimum of 5 will win a car CD player with installation. Please refer to the local or international membership application enclosed in this newsletter.
- ❖ International ITNS is pleased to announce a **New Membership Recruitment Initiative**. Each chapter is encouraged to recruit as many new members as possible. The Chapter that recruits the most new members between January 1, 2004 - March 31, 2004 will receive one free symposium registration to the ITNS conference in Vancouver. Talk to your transplant colleagues and encourage them to join ITNS!!! This is a win-win situation...Your colleagues will reap the benefits of ITNS membership and your chapter will have the opportunity to compete for the free symposium registration!! If each member recruits just one new member, we will double our ranks!!
- ❖ **THANK YOU** to Karen Emmett and Terri Morris. They have volunteered to photograph great moments at ITNS events!!!! Look for these photos in future newsletters!!
- ❖ Support Team Pittsburgh at the **Transplant Olympics** coming up in July, 2004. Cookbooks are still available!! They are \$13.00 or 2 for \$25.00!! Shelley Zomak can be contacted via email (zomakra@msx.upmc.edu) with questions and to make a purchase.
- ❖ A Transplant Nurse Job Analysis Survey will be available soon. This is an important step in the development of the **Certified Clinical Transplant Nurse Examination**. The ABTC executive office has been notified that we are interested in receiving and responding to this Survey since it will become the exam matrix from which the test will be written. Updates regarding the status of this exam development are available on the international website, www.itns.org.
- ❖ **THANK YOU** to Dan Foust from Roche Pharmaceuticals, Inc. for hosting our December Board of Directors meeting.

Assistance needed in the following areas:

- ❖ Newsletter Committee - The goal is to facilitate, collect, and organize materials and information for the development of the GTC quarterly newsletter.
- ❖ Membership Committee – The goal of this committee is to enhance recruitment and retention of ITNS members.
- ❖ Volunteers are needed to staff an exhibit table at a local conference at the Pittsburgh Hilton in April, 2004. The table will have ITNS materials as well as donor and transplant related materials for distribution. Our role will be to distribute the materials and answer questions about donation and ITNS.
- ❖ Anyone interested in assisting in the above areas should contact Chris Shay at shaycl@upmc.edu. CEPTC's are available for committee involvement.

Patient Resources: *Patient education CDs are available through the ITNS website (itns@msn.com) for renal, heart, and liver transplantation*

TRANSPLANT UNITS MOVE TO UPMC MONTEFIORE HOSPITAL
by
Kathy Henderson, RN, BSN

It's official. We Moved! December 31, 2003 wasn't just the end of a year. It was the beginning of a new adventure. After months of anticipation and numerous delays, the Liver Transplant Intensive Care Unit (LTICU) and the Abdominal Transplant Unit have relocated. The LTICU's new home is on 5E/W/N Montefiore and is now the TICU (Transplant Intensive Care Unit). It is a 28-bed unit under the direction of Tracey Grogan, RN, MSN. The Abdominal Transplant Unit, which at one time was Unit 10D Liver Transplants and Unit 12D Kidney Transplants, resides on 12 North & 12 South and is under the direction of Lisa Fox-Hawranko, RN, MSN. Twelve South is a 35 bed non-monitored unit and 12 North is a 25-bed telemetry unit with the capability of a 9 bed step-down unit. The phone numbers are 412-648-6490 and 412-648-6420 respectively.

ACKNOWLEDGEMENTS

The Golden Triangle Chapter of ITNS would like to thank the following local businesses for their generous support of our Educational Fund. Their donation of raffle items is greatly appreciated!

Alex's Flowers
Carnegie Museum of National History
Dance Alloy
Gateway Clipper Fleet
Improv, America's Original Comedy Showcase and Restaurant
National Aviary
Papa John's Pizza
Phipps Conservatory and Botanical Gardens
Pittsburgh CLO
Pittsburgh Zoo & PPG Aquarium
Senator John Heinz Pittsburgh Regional History Center
The Andy Warhol Museum
Wyndham Garden Hotel, University Place

Apology/Correction to Article in last Newsletter

The 20th Anniversary of the pediatric heart transplant program was celebrated on February 14, 2002 . Dr. Steven Webber, Medical Director of the Heart and Heart-Lung Transplant Program, discussed heart transplantation—its history, challenges and future promises. Dr. Eric Sklarew, ENT surgeon in Bethesda, MD, described his unique transition from being a health care provider to a receiver as his young daughter received an orthotopic heart transplant in 2002.

