The Renal Pharmacist

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What's new with cholesterol guidelines?

Submitted by Brenda Bruinooge, York Central Hospital, Richmond Hill, ON

It is a sad statistic that cardiovascular disease still causes 37% of all deaths per year in Canada. It is estimated that 1 in 4 Canadians has coronary artery disease (CAD), while 1 in three has some type of dyslipidemia. We know from longitudinal studies that dyslipidemias can put patients at risk of MI or repeat MI's and yet only 30% of patients with dyslipidemias get appropriate therapy to modify their risks of CAD.

With these sobering remarks, Wendy Gordon, Clinical Pharmacy Specialist in the Cardiology and Cardiac Surgery program, at Royal Columbian Hospital in New Westminister, BC, began a review of the "new" clinical practice guidelines for the management and treatment of dyslipidemia, at the 4th Annual Contemporary Therapeutic Issues in Cardiology and Nephrology, held in Toronto, May 26 and 27, 2001 sponsored by Aventis. The last time guidelines were published in Canada was in 1988 and the guidelines were based on the available studies at the time: small sample sizes, short follow-up periods using angiographic evidence for outcomes. The new guidelines incorporate some bigger studies and look at primary and secondary outcome data with study periods of greater than 5 years.

If you are like me, I am happy to know my patients are getting their cholesterol checked, but the numbers are reported in hieroglyphics with codes such as "reference range is age and sex dependant." When Wendy was finished with the background information on the guidelines, she took us into breakout groups and had us review real cases. What a difference a few practice cases made to improve daily practice for me! Let me try to summarize some of her points for you.

Cont. of page 2

In This Issue

From your RPN Chair.....

The RPN executive has once again been busy. Our mission statement, goals and job descriptions of the Executive positions have been recently updated. We have met with Ortho-Biotech to develop a financial plan as we are incurring more expenses with the website, Newsletters and continuing education evenings. Networking and bridging between other provincial renal pharmacists has begun, however most of our efforts have been to get the website off the ground to make it useful to our members. Thus far, feedback has been positive about the website.

On a personal note, I have been volunteering for the government Relations Committee for the Kidney Foundation of Canada. This group meets 4 times a year. Although I represent a member-at-large on this committee, with my experience as Chair of the RPN and as a clinical pharmacist in a dialysis program I have been able to help identify, support and influence public policy issues relevant to the Foundations missions. In November we met at Queen's Park to introduce the Ontario Renal Voices outreach program. The purpose of this program is to educate, establish ongoing Interchange of information and share knowledge with the MPP's and the Kidney Foundations branches and chapters. The overall goal is to positively influence the development of government policy affecting patients with renal failure and their families. If you are interested in volunteering for your area, please contact myself (Jennifer Brick).

Elections are coming up in September. Please advise Jennifer Brick of your interest to be part of the RPN executive!!

What's new with cholesterol cont.

The new Canadian guidelines were released April 2000 and have some specific improvements over the 1988 guidelines:

- Therapy in diabetics and those with established CAD is much more aggressive
- The LDL target for those at highest risk of CAD has been lowered to 2.5 from 3.0 mmol/L
- While lifestyle modifications are still important, if treatment is initiated with diet therapy alone, a patient is only given 3-6 months to reach targets, based on the risk category. Those at moderate risk are given 3 months; those at low risk are given 6 months. Those at high or very high risk are started pharmacological therapy along with lifestyle changes.

The 2000 guidelines stratify a patient into 1 of 4 risk categories based on their total points from a risk table[1] that assigns "risk points" based on a patients age, gender, cholesterol level, HDL level, blood pressure at time of test and smoking history. The total risk points are tabulated and a 10-year risk in percent is obtained. A low risk person will have a 10-year risk of a coronary event of < 10%, a moderate risk person 10-20%, high-risk person 20-30% and very high risk person (includes anyone with established CAD or any diabetic) > 30%. Once the risk level is determined, the target LDL-C, Total Cholesterol (TC) to HDL-C ratio and Triglyceride (TG) values are determined from another table – see Table 1.

Table 1.
Target lipid values by level of risk (from CMAJ 2000; 162(10): 1444)

Risk level	Target Values		
	LDL-C mmol/L	TC/HDL-C Ratio	TG mmol/L
Very high	< 2.5	< 4	< 2.0
High	< 3.0	< 5	< 2.0
Moderate	< 4.0	< 6	< 2.0
Low	< 5.0	< 7	< 3.0

Once target levels are determined, pharmacological therapy can be initiated based on the principles in table 2.

[1] See the actual guidelines for the risk table.

Table 2
Drugs of choice for different abnormal lipid profiles
(from CMAJ 2000; 162(10):1445)

Lipid profile	Drug of choice
Elevated LDL-C	Statin ± resin
+ moderately ↑ TG	Statin
+ ↓ HDL-C	Statin + fibrate OR statin + niacin
Normal LDL-C	
+ ↑ TG	Niacin OR fibrate ± statin
+ low HDL-C	Niacin OR fibrate ± statin

As you may recall, fibrate therapy in renal failure patients is fraught with uncertainty. What dose to use? How high is too high? In general, our centre uses Lipidil Micro® 67mg daily (generic from APO is now available too) or Lipidil Micro® 200mg q2d or Bezalip® 200mg q3d. Are any other units following similar patterns of use? Does anyone have any comments on these doses? Doses of these pharmacological agents are adjusted at q3 monthly intervals until therapeutic endpoints are met and then q6 months unless in the high or very high risk category (then q3 month).

To summarize the patient impact of lipid lowering therapy, in the primary prevention studies, the numbers needed to treat (NNT) to prevent acute MI, or death is approximately 40-50. For the secondary prevention studies, the numbers needed to treat are even smaller at 30 patients.

Sadly, in Wendy Gordon's practice, the screening of dyslipidemias is not routine for inpatients and starting new lipid lowering therapy in hospital is often clouded by the interference with heparin IV (can falsely lowers results), resulting in few new patients beginning on dyslipidemia therapy. Our hospital still regards Statins as "non-formulary" based on the flawed assumption that lipid therapy is a "non-acute" treatment goal to be managed by a family physician upon discharge.

According to Wendy, only 50% of all patients are screened by family physicians, of these, 35% of patients start therapy; patient groups often ignored are the elderly or women. Once on treatment, it appears as though only 1/3 reach their target levels clouded by the fact that the 1-year compliance rate is only 60%. Lack of dose titration and poor compliance is preventing optimal health outcomes!

Cont. on page 3

Cholesterol cont.

Are other Dialysis programs in Canada experiencing these abysmal statistics that Wendy presented? Certainly in my own practice, we do not initially test cholesterol levels with the presumed assumption that fasting levels must be obtained (which are difficult to get in the 2nd and 3rd HD shifts, and PD/PRI patients coming for later appointments). If patients get their levels tested at an outside lab, follow-up of the results is difficult and time-consuming to say the least.

Wendy challenged us to work within our hospital settings to set up initial therapy in hospital through preprinted order forms, education of prescribers and patients and encouraging follow-up by empowering patients to get involved in their care. Multidisciplinary clinics help co-ordinate care to assess patient outcomes, as Wendy does in her Dyslipidemia Clinic. She challenged us to develop patient tools to get the information to the patients who could challenge their physicians to assess outcomes on a more frequent basis. I have started to use the risk assessment table and a cartoon type educational tool in my practice. The educational tool gives my patients the knowledge they need to have a discussion with their nephrologist. A copy of the educational tool is kept on the chart for the team to refer to.

I'd like to challenge each of you to share strategies you use to tackle the dyslipidemia issue the with the RPN members. Suggestions for things to share include

- Educational pamphlets
- Blood work protocols including how often is cholesterol re-checked.
- How do the units handle the issue of afternoon and evening Hemo patients needing cholesterol tests (are they able to provide a fasting test or do your nephrologists ignore the requirement for a fasting state?)?
- Dosing guidelines of agents including fibrates

Please forward any information to myself and I will compile the information and share it with everyone in the next issue or so. I will also post this topic on the RPN web site in the discussion forum; so if it is easier to post a message, go ahead! I look forward to hearing from you! Contact me at bbruinooge@yorkcentral.on.ca or 905-780-4278

P.S. The guidelines for the management and treatment of dyslipidemias can be found in CMAJ May 16, 2000; 162(10): 1441-1447.

Member Profile

Laura Hunter

Laura is a bit of a legend when it comes to renal pharmacy. When she's not on the golf course or getting flooded out of her office, she is busy being a great renal pharmacist. It has been the focus of her career. A graduate of the University of Florida, she started her renal career covering a maternity leave at The Wellsley Hospital, Toronto, ON before accepting a career at the Oshawa General Hospital, ON in the Renal Program (1991). She has been active in implementing a pharmacy clinical focus into the Renal program (as she was predominantly doing distribution-related activities until 1995). Once they saw her in action, there was no turning back. She is now one of a 3 FTE team and is responsible for approximately 150 PRI and approximately 150 HD patients.

Laura is the "founder" of the RPN in Ontario. She was instrumental in beginning the group with Ann McLean of Ortho-Biotech, as she clearly saw the need to share and learn from other renal pharmacists. She has held positions on the executive of RPN for the last 4 years (Secretary '97-'98, Vice Chair '98-'99, Chair '99-'00, Past Chair '00-'01), and is definitely looking forward to a reprieve with September's executive turnover. Laura also sits on the Medical Advisory Committee for the Kidney Foundation of Canada.

In her spare time you will find Laura on the GOLF course. She likes to do crafts and is a movie fan. Did I mention she loves to GOLF?!?!

Thank you Laura for your initiatives. You have started a legacy that will continue to grow and flourish. Patients everywhere are benefiting from our RPN.

/LS

RPN History

Submitted by Roza Berkowitz,

The concept for the RPN originated from the innovative European model for the Anemia Coordinator (AC). Renal Pharmacists who held the AC position in Europe expressed the need to exchange information and ideas that specifically held a pharmacy focus. The excitement seen in this European RPN Community inspired the birth of a "Canadian contingent" back in 1996.
In partnership with Ortho Biotech, Laura Hunter from Lakeridge Health Centre in Oshawa was the "founding" pharmacist who spearheaded the development of the RPN in Ontario. Way to go Laura!!

All tied up with the LOGO!!

Well it was a tie! After a long and grueling decision making process and cause-effect analysis (no really – we only had 5 submissions), the RPN executive could not come to one final decision on our Logo contest winner. This may have had something to do with the fine dining and wine, but mostly because we decided a combination of two of the submissions would encompass our vision of a representative logo. Therefore, I would like to congratulate Lori MacCallum (St. Mike's Hospital, Toronto, ON) and myself (Jennifer Brick, Grand River Hospital, Kitchener,ON) for winning the contest. Lori will receive a basket of Neutrogena Products donated by Ortho-Biotech. Thanks to all those who submitted ideas (James, don't give up your day job – haha). Remember to check out the webpage to see our new logo in action soon and keep an eye out for it on future correspondence.

Jennifer Brick, Chair, RPN

A Day in the Life

Submitted by Sean Albanese, Thunder Bay Regional Health Centre

I was counselling a 65-year-old Native woman with Diabetic Nephropathy in our PRI clinic recently. She was with her son who served as a translator as she did not speak English. The medical chart stated that she was from Sandy Lake, a Native Community of about 2000 people. She was actually from a much smaller community a few hours from Sandy Lake by boat. We had started her on Erythropoietin previously due to anemia of renal failure. Her hemoglobin on this visit was 105 g/L. I asked her about the Erythropoietin and reminded her that it needed to be kept in the fridge. The conversation was as follows:

"She doesn't have a fridge", replied the son. "But she does have a freezer".
"No, we definitely do not want the medication stored there" I replied. "Is there a neighbour with a fridge?"
"She says that the only fridge in the community is at the school where the teacher stays", he replied.
"That's the only fridge in the whole community?" I asked.
"It's more like a settlement" he replied.
"Can she speak to the teacher and ask if the drug can be stored in there?"
"She says that she will but the teacher leaves for summer holidays soon"
"And then the fridge will be unavailable?"
"Yes…until September"
"So what are we going to do?"
"Well there is another settlement across the lake where her daughter lives. But it's too long a boat ride to take every day"
"This would only need to be delivered once a week. Is that possible?"
"She thinks so. She says that she will ask her daughter"

A Native Liaison worker in our service indicated that this woman's community is only accessible by boat and floatplane in the summer and in the winter by ski plane and snowmachine. During the spring and fall the ice breaks up freezes up respectively creating a greater problem. During these times, nobody can enter or leave the community.

This story indicates some of the situations and challenges that can occur with a Renal Service looking after remote communities.

THE OPTIMAL CARE COORDINATOR PROGRAM

Submitted by Roza Berkowitz, Credit Valley Hospital, Mississauga,ON

Goal:

To provide a comprehensive educational program to support and enhance the practice of the Optimal Care Coordinator (OCC) in promoting optimal management of anemia across the continuum of renal patient care.

Origin

In the mid 1990's, Janssen-Cilag, the European affiliate of Ortho-Biotech, developed a highly successful Anemia Coordinator program that currently operates widely throughout the European nephrology community. As in Canada, the position in Europe has been held by a pharmacist or a nurse who had extensive nephrology experience. In Canada, the Anemia Coordinator position evolved into an Optimal Care Coordinator position that is patient based and patient- outcome focused. The CQI fundamentals of this position empower the OCC to address many problems encountered during the continuum of care in the chronic renal insufficiency patient.

Launch, Training and Implementation

In May 2000, Ortho-Biotech launched the Optimal Care Coordinator program in Toronto, Ontario. Numerous waves of training for the pharmacy and nursing participants have seen the development of over 60 OCC's across Canada.

	Wave 1 Trainee's (17)	Wave 2 Trainee's (43)	Wave 3 Trainee's
Basic Training	May 2000	Feb 2001	TBA
Advanced Training #2	November 2000		
Advanced Training #3	June 2001		

The 3 day basic training program was provided the OCC's with a mix of didactic and interactive educational sessions presented and facilitated by experts in the field of anemia management and continuous quality improvement (CQI). Topics covered during this comprehensive workshop included the following:

* Early treatment of anemia
* Symptom Management
* Iron Management
* Bone Disease
* Diabetic Nephropathy
* Development of a sixty day action plan
* Continuous Quality Improvement

The advanced training sessions provided comprehensive workshops that addressed the following:

* Critical appraisal of clinical research
* Cardiac manifestations of anemia
* Advanced continuous quality improvement workshop
* Optimizing response to Eprex*
* Sharing success stories amongst OCC's
* Continuation with action plans
* Microsoft Excel training
* Role and Responsibilities of an Optimal Care Coordinator
* To work in collaboration with the other members of the multi-disciplinary team
* Promote optimal management of anemia in patients with chronic renal insufficiency through the development and implementation of ongoing patient assessment, education and monitoring processes in the clinical setting.
* Incorporate CQI management principles and processes into the clinical setting.
* Identify, implement and evaluate clinical outcome indicators specific to anemia management.
* Collect and utilize data to monitor the quality of patient care.
* Adopt methods for measuring and benchmarking patient outcomes and clinical processes.

Treatment of Hypocalcemia Calcium with meals or empty stomach?? That is the question

Submitted by Lisa Sever, York Region Dialysis Program, Richmond Hill ,ON

Hypocalcemia is a common electrolyte abnormality found commonly in Progressive Renal Insufficiency patients secondary to compromised Vitamin D metabolism, resulting in decreased gut calcium absorption. Hypocalcemia is also common post parathyroidectomy surgery.

In both cases I have seen patients prescribed calcium carbonate supplements to be administered on an empty stomach (i.e. in between meals) with the presumed assumption that they will not be binding phosphorus, so they will be maximally absorbed. Is this a correct assumption? Reviewing the chemical properties of calcium carbonate you will find that Calcium carbonate is a hard, insoluble salt that requires maximal amounts of stomach hydrochloric acid to aid in its dissolution. Stomach acid is at its lowest during times of fasting. We must also consider that most of our patients are elderly (the population with the highest incidence of achlorhydria), and that many of our patients are on acid suppressant medications (Proton pump inhibitors or H2-antagonists). Even the label on a bottle of Calcium carbonate states for Calcium supplementation take at the end of a meal, based on the assumption that stomach acid levels are high to aid in food digestion.

I would suggest for treating hypocalcemia that a daily Vitamin D analogue be initiated inconjuction with calcium carbonate taken with meals. If this combination does not elevate serum calcium levels sufficiently, you could switch to a more soluble calcium supplement such as Calcium sandoz liquid or effervescent tablets in between meals and/or increase the dose of the Vitamin D analogue.

I encourage you to respond with feedback on this issue to l.sever@aci.on.ca

Product News

Diavite / Replavite

Drug acquisition nightmares have been plaguing Renal pharmacists this summer. Diavite has been discontinued for distribution in Canada, effective immediately. The substitute Replavite is currently on backorder until September 2001. Landmark Medical has plenty of stock of the bottles of 500 tablets available to sell to hospitals, but the expiry date is August 2001. We have been reassured that Replavite will become available for September 2001. The only difference between Diavite and Replavite is the Vitamin C content (60mg Vs 100mg).

Calcium Acetate

As Stanley Pharmaceuticals has been recently bought out by VitaHealth Pharmaceuticals, there has been a disruption in the distribution of Calcium Acetate. VitaHealth has been contacted regarding its distribution, but currently has no answers regarding when it will become available again. In the meantime, Phos-Lo is available through the Special Access Program, but because it has no DIN, provincial plans will not pay for it!! Watch the website for updates.

Renagel (Ontario and Quebec)

We have just received word that Renagel® (Sevelamer) will be covered under the provincial drug benefit programs by Section 8 submissions (in Ontario) if warranted (i.e. uncontrolled phosphate levels, and intolerance to calcium salts). Contact Genzyme for further information. A section 8 form is available from Genzyme or from the www.renalpharmacists.net (slightly modified).

Venofer

Venofer (Iron Sucrose Hydroxide) now has a DIN, therefore you no longer have to obtain it through the Special Access Program. There have been lots of safety studies published in the last year on Venofer. Has anyone taken the time to summarize them? Please submit an article to the next Renal Pharmacist to share the information.

Articles of Interest

Visit www.renalpharmacists.net for a more comprehensive list and to be linked directly to the abstracts. / LS

Sodium Ferric Gluconate Complex in the Treatment of Iron Deficiency for Patients on Dialysis. Steven Fishbane and John Wagner. Am J Kidney Dis 2001 37: 879-883.

Effect of Lisinopril on the progression of renal insufficiency in mild proteinuric non-diabetic nephropathies Giulio A. Cinotti and Pietro C. Zucchelli. Nephrol. Dial. Transplant. 16: 961-966.

A randomized study of oral *vs* intravenous iron supplementation in patients with progressive renal insufficiency treated with erythropoietin. John Stoves, Helen Inglis, and Charles G. Newstead. Nephrol. Dial. Transplant. 16: 967-974.

A randomized, controlled parallel-group trial on efficacy and safety of iron sucrose (Venofer®) *vs* iron gluconate (Ferrlecit®) in haemodialysis patients treated with rHuEpo Markus Kosch et al. Nephrol. Dial. Transplant. 16: 1239-1244

Fibrate treatment can increase serum creatinine levels V. Tsimihodimos, A. Kakafika, and M. Elisaf. Nephrol. Dial. Transplant. 16: 1301.

The role of iron status markers in predicting response to intravenous iron in haemodialysis patients on maintenance erythropoietin. Nicola Tessitore et al. Nephrol. Dial. Transplant. 16: 1416-1423

Methylene blue, a nitric oxide inhibitor, prevents haemodialysis hypotension. Gary Peer et al. Nephrol. Dial. Transplant. 16: 1436-1441.

A randomized, double-blind, placebo-controlled trial of supplementary vitamins E, C and their combination for treatment of haemodialysis cramps. Parviz Khajehdehi et al. Nephrol. Dial. Transplant. 16: 1448-1451.

Better microvascular function on long-term treatment with lisinopril than with nifedipine in renal transplant recipients. Anders Åsberg et al. Nephrol. Dial. Transplant. 16: 1465-1470.

Trisodium citrate 30% *vs* heparin 5% as catheter lock in the interdialytic period in twin- or double-lumen dialysis catheters for intermittent haemodialysis. Koenraad J. F. Stas, Johan Vanwalleghem, Bart De Moor, and Hilde Keuleers. Nephrol. Dial. Transplant. 16: 1521-1522.

Coadministration of Losartan and Enalapril Exerts Additive Antiproteinuric Effect in IgA Nephropathy Domenico Russo et al. Am J Kidney Dis 2001 38: 18-25

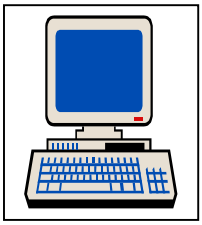
Recreational Drug Use: A Neglected Risk Factor for End-Stage Renal Disease Thomas V. Perneger, Michael J. Klag, and Paul K. Whelton Am J Kidney Dis 2001 38: 49-56.

A Crossover Study of Gabapentin in Treatment of Restless Legs Syndrome Among Hemodialysis Patients Micah L. Thorp, Cynthia D. Morris, and Susan P. Bagby Am J Kidney Dis 2001 38: 104-108.

Optimizing Erythropoietin Therapy in Hemodialysis Patients Donald Richardson, Cherry Bartlett, and Eric J. Will Am J Kidney Dis 2001 38: 109-117

Administration and Clearance of Amphotericin B During High-Efficiency or High-Efficiency/High-Flux Dialysis
Hiie M et al. Am J Kidney Dis 2001 37: E45.

Effect of *L*-Carnitine Supplementation in Hemodialysis Patients
E. Veselá, J. Racek, L. Trefil, V. Jankovy'ch, M. Pojer
Nephron 2001, **88**:**3**:218-223.



How do you tell your patients to take their calcium carbonate binders?

1. At the beginning of their meal
2. During their meal
3. At the end of the meal
4. Anytime during their meal

Please e-mail or phone your answer to me at l.sever@aci.on.ca or 905-780-4278. I will tabulate the results and present the evidence found in the literature in the next newsletter. /LS

Survey
HEPARIN IN PERM CATHETERS (EACH LUMEN) POST DIALYSIS

Submitted by Jennifer Brick, Grand River Hospital, Kitchener, ON

HOSPITAL		COMMENTS
Lakeridge Health Oshawa, Ontario	5000 U + qs with Normal Saline (NS) to fill volume	2000 U and qs with NS to fill volume – rarely is still used
Georges Dumont, Moncton, New Brunswick	fill volume with 10 000 U/mL of solution	bleeders are placed on tricitrasol as an anticoagulant
Grand River Hospital, Kitchener, Ontario	10 000 U + qs with NS to fill volume	rarely 5000 U + qs with NS is used
St. Michael's Hospital, Toronto, Ontario	fill volume with 10 000 U/mL of solution	if patient has a fistula/graft starting to use (only using one needle) qs to volume of line with 1000 U/mL of solution
St. Joseph's Hospital, Hamilton, Ontario	Long-term dialysis catheters: → 10 000 U + qs with NS to fill volume Short-term central lines → 5000 U + qs with NS to fill volume	
Charles Le Moyne, Greenfield Park, Quebec	5000 U + qs with NS to fill volume	Sodium Citrate locks under investigation
Thunder Bay Regional, Thunder Bay, Ontario	fill volume with 10 000 U/mL of solution	
Oakville Dialysis Unit, Oakville, Ontario	2500 U + qs with NS to fill volume	
St. John's Regional Hospital, St. John, New Brunswick	5000 U + qs with NS to fill volume	contemplating filling volume with 1000 U/mL of solution.
BC Children's Hospital, Vancouver, British Columbia	Children: 2500 IU + qs with NS to fill volume	if patency problems, increase to 5000 IU or up to full volume with 10 000 IU/mL
The Hospital for Sick Children, Toronto, Ontario	Adults: 3750 U + qs with NS to fill volume Children: 25000 U + qs with NS to fill volume	all kids are on warfarin

Executive Committee Members and Responsibilities

Chair

- one year term
- chairs meetings
- develops links with other Provinces on networking
- serves as a primary liaison with other organizations
- oversees recruitment of sponsorship for functioning of the Network
- strikes ad hoc task forces as needed
- edit / review newsletter prior to distribution
- review corporate funding status yearly

Vice Chair

- one year term
- assumes role of Chair in subsequent year
- assists the Chair in carrying out the responsibilities, and assumes the role of Chair in his/her absence
- implements new projects as identified
- edit / review newsletter prior to distribution

Secretary / Treasurer

- one year term
- sets agenda for meetings
- takes minutes of general and committee meetings
- ensures minutes and agenda are mailed in a timely matter
- ensures membership list is updated
- maintains financial account of Network and prepares year-end report

Educational Coordinator

- one year term
- chairs and coordinates National Multidisciplinary Conference task force
- seeks ideas for educational topics and speakers
- ensures contact with speaker is made and sends letter of confirmation to speaker
- works with sponsor in coordinating educational events, such as location, food, announcements
- facilitates the collections and dissemination of clinical and educational materials to members

Communication Coordinators (2)

- one year term
- solicits submissions for the quarterly Network newsletter
- coordinates and edits newsletter and ensures distribution to members
- works with sponsor in production and distribution of the newsletter
- coordinates maintenance of Web site with task force and designer

Elections are held yearly in September.

Developed July 1997, revised March 2001

Upcoming Conferences

Check www.renalpharmacists.net **for the most recent information.**

August 11-14, 2001
CSHP Annual General Meeting, Halifax, NS,

September 15 and 16, 2001
Sponsored by Aventis, a 2 day event on Cardiology and Nephrology hosted by the Canadian Cardiology Pharmacists Network. Location: Regina, SK. More information to follow.

Sept 28 - Oct 1, 2001 Catch the WAVE at the 2001 CANNT symposium in Moncton, NB. Visit http://www.cannt.ca/cannt_2001.htm for program information and registration.

October 11-17, 2001
ASN/ISN World Congress of Nephrology. Location: San Francisco, California, USA

Websites of Interest

www.renalpharmacists.net is being transformed into a great website. If you haven't visited recently, make this a reality this week. The discussion forum is active, articles of interest with links to the abstracts, news and events, presentations to view and share, current and backissues of The Renal Pharmacists are posted, many great links to other websites….. The list continues. We have had many pharmacists register and benefit from using the site (the feedback has been glowing!) All renal pharmacists should log on and check it out.

Classifieds

Wanted - Which dialysis centres in Ontario are currently billing ODB or private insurance plans for IV iron dextran? What does the Hospital Act state about this practice? Please respond to Lori D. Wazny, Pharm.D., B.Sc.(Pharm), Nephrology Clinical Specialist.
Southwestern Ontario Regional Self Care Dialysis Centre.
Department of Pharmacy
London Health Sciences Centre, 375 South Street
London, ON N6A 4G5
Phone: (519) 685-8500 ext. 75013
E-mail: Lori.Wazny@lhsc.on.ca

Wanted -Please forward to me good summary articles in all areas of renal pharmacy. This will be posted on the website for all to access to help standardize training and ease the learning curve for all "new to renal" pharmacists. Great idea from British Columbia (right Dana??). Please e-mail titles, authors and journal (or abstract) to l.sever@aci.on.ca or fax to my attention (Lisa Sever) 905-883-8122.

Fresh blood wanted – The RPN executive turns over in September. Please be thinking about which position you would like to be nominated for (or accept a nomination if it comes your way!) The positions and their descriptions are posted on our website www.renalpharmacists.net or on page 9 of this Newsletter. The 2001-2002 term promises to be very exciting as we progress towards networking with all renal pharmacists across Canada, further develop our website and plan our participation in a Multidisciplinary Canadian Renal Conference.

Notice – Address / Info Changes

Please forward any address / phone number changes to the Secretary / Treasurer, Andrea Fox. Her e-mail is foxa@smh.toronto.on.ca We are constantly updating our membership mailing list. Thank you.

A great big Thank You!

To all of those who contributed (especially the new contributors!!) and to Ortho Biotech for printing and distributing the newsletter!

Deadline for submissions for next Newsletter is September 30,2001 Please e-mail, fax or call Lisa Sever, Communications Co-ordinator, using the contact information on the front of this Newsletter.