The Renal Pharmacist

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ADDRESS/INFO CHANGES

Please forward any address / phone number changes to the Secretary / Treasurer. Her e-mail is hjennings@lakeridgehealth.on.ca. We are constantly updating our membership mailing list. Thank you.

View from the Chair

Countless people were affected by Hurricane Katrina in New Orleans in August. When thinking about all the people that were evacuated from this area, my mind wandered to dialysis patients and wondered what would become of them. Were they able to arrange alternate dialysis means? How would PD patients be able to get supplies and perform their dialysis? Luckily, there were programs to in place to assist these patients, however, it will take a lot of financial support to rebuild these programs. We were approached to assist with our colleagues down south and the RPN responded to the need with a donation to the Kidney Foundation's Hurricane Katrina Fund. If you are interested in further details, please refer to www.kidney.org.

The RPN has continued with our commitment to provide ongoing educational events to our members. This year's CANNT conference in Halifax was the 4th year of the RPN's partnership with CANNT. The RPN sessions were well attended and we were pleased to receive positive feedback from the attendees. We are looking forward to our upcoming symposium session at the PPC in Toronto and excited to start planning for next year's CANNT conference in London, Ontario.

September marked the changeover for the RPN executive. We have made a few changes to the executive committee over the past year including adjusting to one education co-ordinator and forming a website committee. We recognize that there is a lot of work in the development and maintenance of the website. We hope that with the formation of a website committee, we will be better able to improve our website as a communication tool for our members. Also, beginning next year, changeover of the RPN executive will be in December to complement our annual planning. We always welcome new members and volunteers for the executive. If you are interested in participating, please contact us.

As the outgoing chair, I would like to thank the RPN executive for their support over the past year and for all their hardwork and dedication to the network. It has been a great learning experience and an absolute pleasure serving as the Chair of the RPN. We are looking forward to having Marisa Battistella leading the RPN in 2006!

Signing off...
Jenny Ng
Past Chair, Renal Pharmacist Network

IN THIS ISSUE ...

CHECK OUT OUR WEBSITE AT **www.renalpharmacists.net**

Heparin vs Citrate for CVC Lock Therapy

Results of an e-mail survey sent via RPN website

Summarized by Lisa Sever, Nephrology Pharmacist, York Region Dialysis Program, Richmond Hill, ON

A total of 21 Canadian dialysis centres responded to the survey which asked "Does your centre use Heparin or sodium citrate for anticoagulation during hemodialysis and for capping lines?" What adverse effects has your centre attributed to the use of Heparin or sodium citrate?

All 21 centres use Heparin for circuit anticoagulation. Problems reported with using heparin have been heparin-induced thrombocytopenia (HIT), bleeding, rash and pruritis. Most centres use Danaparoid in patients unable to tolerate Heparin, or saline flushes. Bruce Lange from RCH Renal program in BC reports "we have a citrate (ACDA) anticoagulation protocol for patients with HIT or in whom systemic anticoagulation is contraindicated. It is a bit of a hassle using ACDA infusions (e.g. measuring ionized Ca++ and adjusting Ca infusions) & patients have c/o cramps and tingling of mouth/face – so for HIT I tend to suggest danaparoid and we check an anti-Xa level pre HD".

For CVC lock, 9 centres use citrate lock routinely. Both 4% and 2.2% strengths are reported. Centres using 2.2% dextrose citrate are drawing up syringes onsite. The 4% citrate is available in 5ml prefilled syringes through a company called Landmark Medical. An additional 3 centres use citrate 4% to lock the CVC of HIT patients.

Check out the CANNT website for poster abstracts, as Humber River Regional Health Centre (Toronto area) converted their unit recently from Heparin to Citrate 4% lock. It would be a good idea to get their results if your unit is considering the switch.

Our colleagues in New Zealand sometimes use alteplase as a lock in heparin intolerant patients, whereas in the UK, heparin or citrate lock therapy is used.

Thanks to all of the respondants. If you need specific information for citrate lock policy and procedures, please e-mail me at l.sever@aci.on.ca and I can let you know which specific centres are using it.

CANNT 2005 Poster

Understanding Kidney Disease and Medications

A teaching tool for patients to acquire medication knowledge

Lisa Sever, Nephrology Pharmacist, York Region Dialysis Program, Richmond Hill, ON
Shelley Parker, Nephrology Pharmacist, Grand River Hospital, Kitchener, ON

Improving medication adherence is multifactoral. Acquiring knowledge is often presented as one intervention to improve a patient's adherence. Theoretically, understanding how medications work, may allow patients to observe the positive outcomes more readily and increase their understanding of alternate choices if they experience an adverse event. However, this intervention alone is difficult to measure a change in a patient's adherence to their medication regimen.

Patients with chronic kidney disease are on many medications; for balancing altered mineral metabolism; for multiple co-morbidities. Few comprehensive resources in layman's terminology are available to explain the intricate mechanisms of medication therapy in patients with chronic kidney disease (identified through a Google search, surveys to dialysis units and review of Kidney Foundation of Canada materials).

Patients are often given brief explanations about the medication's indication. They may receive conflicting information from their community pharmacist or family doctor when a medication is used for a "renal" indication. Perhaps, standardized teaching using concise, written information regarding the disease process and medication options may prepare them for changes to their medication regimen. They may have increased confidence and ask more questions.

A booklet entitled **Understanding Kidney Disease and Medications** was developed. The readability using the Flesch-Kinkaid scale is 8.5 (suggesting Grade 8 level). Pictures and arial font size 12 were used to give the booklet an "easy to read" appearance. The target audience includes all modalities of chronic renal failure as it allows patient specific targets to be defined. This teaching tool has been designed to be used by Registered Nurses (RN's) and Nephrology Pharmacists. Pages have also been formatted to be individually printed so medication therapy for a single disease state can be reviewed with a patient (e.g. anemia therapy, laxatives, cough and cold). This booklet is available to Nephrology units across Canada in a PDF format or hardcopy. A survey was developed to evaluate the usefulness of the booklet according to the patient. The booklet Understanding Kidney Disease and Medications and survey results will be presented.

For a PDF copy or more information contact Lisa Sever at lsever@yorkcentral.on.ca

The use of LMWH in Patients with Renal Insufficiency

Presented by Dr. Wendy Lim at the RPN Educational meeting, September 20th, 2005
Summarized by Hilary Jennings, Renal Pharmacist, Lakeridge Health Corporation, Whitby, ON

Dr. Lim completed a residency program in hematology and is currently completing a Masters degree in Clinical Health Sciences in the Health Research Methodology Program at McMaster University. Her research interests include anticoagulant use in specific populations, including critically ill patients and patients with renal failure.

Dr. Lim spoke on the topic of low molecular weight heparins (LMWH) in patients with renal insufficiency (RI). There was an impressive turnout of clinical pharmacists from a variety of practice sites.

LWMH offer advantages over unfractionated heparins (UFH) in the general population. Predictable weight-based dosing, lower incidence of side effects, decreased need for lab monitoring and the option for out patient treatment make LMWH an attractive option for anticoagulation. Despite these advantages, LWMH require special considerations in patients with RI.

LMWH are cleared by renal elimination putting patients with RI at increased risk of accumulation and bleeding. This risk is amplified because LMWH cannot be easily reversed with protamine as can UFH.

Anticoagulation with LMWH has been studied in a variety of clinical situations however almost all randomized control trials involving LMWH have excluded patients with RI. The American College of Chest Physicians (ACCP) recommends that if LMWH is chosen despite the fact that safety in patients with RI has not been proven, monitoring of therapeutic anti-factor Xa activity should be performed.

The ACCP guidelines currently recommend UFH for patients with severe renal insufficiency (CrCl $\leq$30 ml/min) requiring therapeutic anticoagulation. Alternately, LMWH may be used at a therapeutic dose if anti-Xa levels are monitored. The timing of anti-Xa levels is important but not completely clear. Dr. Lim suggested a target peak level 1.0-1.5 IU/ml at 4 hr after subcutaneous injection and a target trough level less than 0.5 IU/ml at 20-24 hours post injection. If anti-Xa levels are not monitored the LMWH dose must be reduced empirically. Unfortunately, most empiric dose reduction guidelines are based only on pharmacokinetic studies or data simulations.

Dr. Lim discussed literature which supports the use of LMWH in the hemodialysis circuit. LMWH appears to be as safe and as effective as UFH for the prevention of clotting within the extracorporeal dialysis circuit.

Clearly, further research is required to understand how to use LMWH safely and effectively in patients with renal insufficiency. Dr. Lim's ongoing research in the area will be greatly valued by health care professionals and patients alike.

CANNT 2005 Poster

Keeping the Lines Open:
Sodium Citrate 4% vs. Heparin 10,000 U/mL as a Locking Agent for Central Venous Dialysis Catheters – A Retrospective Analysis

Submitted by Linda Grudzinski, Renal Pharmacist, Humber River Regional Hospital, Toronto, ON

One method used to dialyze patients requiring hemodialysis is through a central venous dialysis catheter. A primary complication that potentially compromises both dialysis adequacy and the life of the dialysis catheter is partial or total thrombosis of the catheter. To ensure patency of the catheter between dialysis treatments, heparin is traditionally instilled as a locking agent.

However, the recent increases in the price of heparin have resulted in significant increased costs of each dialysis treatment.

Historically, sodium citrate 4% was reserved as an alternative locking agent for dialysis catheters in patients with confirmed or suspected Heparin Induced Thrombocytopenia (HIT) or other relative contraindications to the exposure to heparin. In April 2003, our in-centre hemodialysis unit converted to locking all central venous dialysis catheters with sodium citrate 4%, instead of heparin 10,000 U/mL.

A retrospective analysis was conducted to evaluate whether replacing heparin with citrate would ensure long term interdialytic anticoagulation and satisfactory catheter function without exposing patients to the risks of systemic heparinization. Data for the 12 month periods pre and post conversion to citrate was reviewed and included indicators such as: alteplase (rTPA) utilization, rates of catheter-related bleeding, catheter exchange rates and accuracy of INR reporting.

Findings indicate that sodium citrate 4% appears to be comparable to heparin 10,000 U /mL for long term interdialytic anticoagulation of central venous dialysis catheters, avoids patient exposure to the risks of systemic heparinization and is more cost-efficient from a pharmacoeconomic perspective.

HIT Screening – Beware!

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

Immunogenic heparin-induced thrombocytopenia (also termed HIT) is observed in 1-5% of patients, with literature reports suggesting 2.8-12% of the hemodialysis population being affected. It typically presents after 5-10 days of heparin therapy (faster onset if previous exposure within the last 3 months). The onset is independent of the type of heparin, dose or route. A baseline reduction of 30-50% in platelets in patients exposed to heparin should arouse a suspicion of HIT. Thrombotic events can occur in 30-80% of patients while on heparin or days after heparin has been discontinued. If HIT is suspected, alternate anticoagulation should be initiated and other causes of thrombocytopenia should be ruled out. Please note that low-molecular weight heparin has a 90% cross-sensitivity to HIT antibodies, and danaparoid has a 10% cross-sensitivity to HIT antibodies.

Lab tests are available to confirm a clinical diagnosis of HIT. Most popular is the H-PF4 ELISA, which detects immunoglobulins binding to the heparin-PF4 complexes. From the literature, the incidence in dialysis patients having positive antibodies is 4 - 9%.

Here is a summary of our experience. Thirteen patients have been screened for HIT since January 2005, all presenting with a drop of baseline platelets, all on heparin for circuit anticoagulation. Of these patients, 7/13 (54%) were confirmed positive using the ELISA. Once a patient is being tested for HIT, our protocol is to initiate Danaparoid for circuit anticoagulation and for line capping (if needed). A positive HIT screen confirms the need to continue Danaparoid for life!

In April 2005, 3 patient results came back as HIT positive within 2 weeks. As the drug budget for danaparoid soared, a little investigation ensued. After speaking with one of our Nephrologists, calling the laboratory and reading up on the topic it became clear that the ELISA assay had a high sensitivity, but low specificity – thus potential for false positive results. The gold standard for testing HIT is a functional assay called SRA (Serotonin Release Assay). It has high specificity and high sensitivity. The SRA must be done within 6 weeks of the patient's last exposure to heparin.

These 3 patients were tested with SRA. All 3 were confirmed negative for HIT. Another 3 patients in August who were positive with ELISA, were confirmed negative with SRA as well. A procedure has been established within our program now to verify positive ELISA results by confirming with the SRA.

By verifying that these patients do not have HIT has resulted in a cost avoidance of Danaparoid of approximately $3000 per patient per year. Not to mention the cost savings associated with any potential hospital admissions where heparin is indicated. ***It is worthwhile to find out which HIT assay is used at your institution***.

More and more literature is being published about heparin associated antiplatelet antibodies in dialysis patients. These patients do not necessarily have HIT, just antibodies. Three different screening assays are being utilized, but are not comparable. Results are conflicting as some reports suggest the presence of these antibodies increases thromboembolic complications and mortality, others conclude it is a risk factor for vascular access obstructions, while some find no association. Prospective trials to determine prevalence are underway.

References available upon request

ARTICLES OF INTEREST

*Please refer to the website **www.renalpharmacists.net** for a more complete list and links to the abstracts.*

Ariano RE, Fine A *et.al*. **Adequacy of a Vancomycin Dosing Regimen in Patients Receiving High-Flux Hemodialysis**. Am J Kid Dis 2005; Oct 46(4):681-687.

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Beddhu S, Kimmel PL, Ramkumar N, Cheung AK. **Associations of Metabolic Syndrome With Inflammation in CKD: Results From the Third National Health and Nutrition Examination Survey (NHANES III)**. Am J Kid Dis 2005; Oct 46(4):577-586.

Kramer H, Luke A, Bidani A, Cao G, Cooper R, McGee D. **Obesity and Prevalent and Incident CKD: The Hypertension Detection and Follow-Up Program**. Am J Kid Dis 2005; Oct 46(4):587-594.

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Buhaescu I, Covic A, Levy J. **Systemic Vasculitis: Still a Challenging Disease**. Am J Kid Dis 2005; Aug 46(2):173-185.

Poggio ED, Nef PC, Wang X, Greene T, Van Lente F, Dennis VW, Hall PM. **Performance of the Cockcroft-Gault and Modification of Diet in Renal Disease Equations in Estimating GFR in Ill Hospitalized Patients**. Am J Kid Dis 2005; Aug 46(2):242-252.

Macdougall IC, Roche A. **Administration of Intravenous Iron Sucrose as a 2-Minute Push to CKD Patients: A Prospective Evaluation of 2,297 Injections**. Am J Kid Dis 2005; Aug 46(2):283-289.

Capitanini A, Lupi F *et.al*. **Gastric pH, sevelamer hydrochloride and omeprazole**. Clin Neph 2005; Oct 64(4):320-322.

Provenzano R, Bhaduri S and Singh A.K for the PROMPT Study Group. **Extended epoetin alfa dosing as maintenance treatment for the anemia of chronic kidney disease: the PROMPT study.** Clin Neph 2005; Sept 64(2):113-123.

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Product Update

EPREX (EPOETIN ALFA) STERILE SOLUTION PRE-FILLED SYRINGES

In November, Ortho Biotech announced the re-approval from Health Canada of the subcutaneous route of administration of EPREX* Sterile Solution pre-filled syringes (PFS) for patients with anemia due to chronic renal failure. A new monograph has been issued as of November 29, 2005 with revisions that reflect the re-approval of the subcutaneous route of administration of polysorbate-80-containing pre-filled syringes for patients with anemia due to chronic renal failure and provide clarity around the occurrence of pure red cell aplasia (PRCA).

Technical investigations have identified organic compounds leached from uncoated rubber stoppers in pre-filled syringes containing polysorbate-80 as the most probable cause of the increased incidence in immunogenicity. Currently, all EPREX pre-filled syringes contain fluoro-resin coated stoppers, which has contributed to a decreased incidence of PRCA with continued surveillance. More detailed information can be found in a publication by Boven et al (2005)† which provides epidemiologic, chemical and immunologic data that support the hypothesis that leachates from uncoated rubber syringe stoppers caused the increased incidence of PRCA associated with EPREX.

EPREX is available in the following formats for both subcutaneous and intravenous administration:

Pre-Filled Syringes:	1,000 IU/mL	5,000 IU/mL
	2,000 IU/mL	6,000 IU/mL
	3,000 IU/mL	8,000 IU/mL
	4,000 IU/mL	10,000 IU/mL

* all pre-filled syringes have a 5-beveled edge 27 gauge needle

Multi-Use Vial: 20,000 IU/mL

† Boven K, Stryker S, Knight J, Thomas A, van Regenmortel M, Kemeny DM et al. The increased incidence of pure red cell aplasia with an Eprex formulation in uncoated stopper syringes. Kidney Int 2005; 67(6):2346-2353.

New Strengths of EPREX (epoetin alfa) Sterile Solution Pre-Filled Syringes Approved for Reimbursement in Ontario

Ontario Special Drugs Program has recently approved EPREX 5,000 IU/mL, 6,000 IU/mL and 8,000 IU/mL pre-filled syringes for reimbursement for patients with anemia due to chronic renal failure. Now all CRF patients in Ontario have access to all of the above formats of EPREX.

SENSIPAR (CINACALCET) UPDATE FOR ONTARIO

The Drug Quality and Therapeutics Committee (DQTC) has completed a review of Sensipar (cinacalcet) for the treatment of secondary hyperparathyroidism in patients with chronic renal disease. It was noted that while Sensipar has been shown to impact parathyroid hormone and serum calcium levels, there is insufficient evidence to support the therapeutic efficacy of this product in achieving clinically important outcomes such as quality of life, symptomatic bone disease, hospitalizations, cardiovascular disease and mortality when compared to conventional therapy. Furthermore, the cost-effectiveness of Sensipar has not been established. In view of the above, the committee has recommended that this product not be reimbursed under the Ontario Drug Benefit program.

LANTUS – SECTION 8 UPDATE FOR ONTARIO

Lantus will be considered for coverage in insulin-dependent patients receiving 2 injections per day who experience 1 or more episodes of nocturnal hypoglycemia (B.S.<3) per week or those having experienced at least 2 episodes of severe symptomatic hypoglycemia (B.S.<3) requiring third party assistance within the previous 12 months. Duration of approval is one year. An extended approval of 1 year is possible with documented reduction of AIC and/or hypoglycemic episodes.

– L.S. and R.R.

CALL FOR ABSTRACTS – CANNT 2006

We would like to extend an invitation to renal pharmacists to submit posters /abstracts for the CANNT conference in London, ON. For more information, contact **Roza Berkowitz** at:

rberkowitz@cvh.on.ca.

Dispensing of Peritonitis Antibiotics: Results of the RPN Survey

Summarized by Lori Wazny. Thank you to all members of the RPN on the e-mail list who responded to the question: "How are peritonitis antibiotics provided to patients?" I received responses from 25 different centres in Canada and as far away as California, New Zealand, and Thailand. Below is a summary table of each of the responses.*

Centre	Vials provided	Predrawn syringes dispensed	Hospital Pharmacy dispenses	Retail Pharmacy dispenses	Comments
RCH Renal Program, New Westminster, BC		X	X (inpatient pharmacy)		Syringes made on as needed basis (not pre-made). Dispensed from PD unit q weekly.
Chilliwack, BC		X		X	
Foothills Hospital, Calgary, AB		Antibiotics put directly into PD bags.		X	Bags delivered to patient's home.
Ottawa Hospital, Ottawa, ON	X				Patient , family member, or homecare nurse reconstitutes.
Scarborough Hospital, Toronto, ON	X (sterile water written as part of script)		X	X (for patients with private insurance)	Occasionally Section 8 letters written for ODB patients. Needles & syringes provided by PD RN from ward stock.
Calgary Health Region, Calgary, AB			X		
Peterborough Regional Health Centre, Peterborough, ON	X (kits provided)		X		All patients living outside city have kits at home. Patient, family member or homecare nurse reconstitutes.
Hotel-Dieu Grace Hospital, Windsor, ON		X	X (if no drug coverage, vials provided)	X (patients with insurance coverage)	
York Central Hospital, Richmond Hill, ON	X (kits provided)				Program covers the cost of peritonitis treatment.
Complexe Hospitalier Sagamie	X			X	All patients keep a 3 day supply of antibiotics at home.
Kaiser Permanente Medical Center, Riverside, CA			X		
Oakville Trafalgar Hospital, Oakville, ON			X		
Thunder Bay Regional Health Science Centre, Thunder Bay, ON			X (if no drug coverage)	X	Sometimes 1-2 days needed to resolve drug coverage issues. Patient then comes to PD unit for antibiotic administration.
Vancouver General Hospital, Vancouver, BC		Antibiotics put directly into PD bags. One week supply filled at a time.		X	1st dose at PD unit. Retail Rx gets bags (provided free) and antibiotics (for a cost) from VGH. Pt either picks up or bags are delivered. Pharmacy bills BC Pharmacare and hospital picks up any leftover cost.
Sunnybrook & Women's College HSC, Toronto, ON	X		X (hospital outpatient pharmacy)		Billed through private insurance or ODB. Program picks up cost for those with no insurance.

Dispensing of Peritonitis Antibiotics: Results of the RPN Survey

continued

Centre	Vials provided	Predrawn syringes dispensed	Hospital Pharmacy dispenses	Retail Pharmacy dispenses	Comments
Kelowna General Hospital, Kelowna, BC		Antibiotics put directly into PD bags.	X		Patients with peritonitis are usually admitted to hospital
Humber River Regional Hospital, Toronto, ON				X (located within hospital)	Billed through insurance. If no insurance coverage, Home Dialysis Unit accepts charge.
Regina General Hospital, Regina, SK		X		X (located within hospital)	Covered by provincial drug plan. Pharmacy bills as a compound. Delivery prohibited.
Grand River Hospital, Kitchener, ON	X (kits provided)		X		
Dunedin Hospital, New Zealand	X (kits provided)				High numbers of rural patients. Patients initiate treatment or take kits to local medical centre. Bag is cultured by central dialysis centre.
Bumrangrad International, Bangkok, Thailand		X	X	X	1st dose given at PD clinic then patients pick up syringes the following day.
Alberta Children's Hospital, Calgary, AB	X				Patient and parent taught during PD training.
London Health Sciences Centre, London, ON	X (kits provided)		X (wardstock fills kits)		Needles provided by RN from PD unit. Patient taught reconstitution during PD training.
Children's Hospital, Winnipeg, MB	X			X	Patient and parent taught during PD training.
Manitoba Renal Program, MB[1]	X			X (outpatient pharmacy)	Manitoba Renal Program picks up cost.

[1] In Manitoba, we put together a working group on this issue since our hospital outpatient pharmacy is set to close in November 2005. The working group consisted of a pharmacy site manager, a renal pharmacist from each centre that has PD (currently 2 hospitals in Winnipeg), myself, PD charge nurses from each site, and the Renal Program nurse managers from each PD site. Our decisions were:

1. We will continue to provide the antibiotics in predrawn syringes for the patients.
2. We will have a retail pharmacy/pharmacies with an IV hood prepare the syringes.
3. The most common antibiotics (cefazolin, tobramycin, ceftazidime, vancomycin) are covered by Manitoba Pharmacare (ceftazidime under Part III) and NIHB (under Prior Approval) and will be billed to these plans.

We are now having discussions with hospital management as to whether we need to tender out this service as we are not allowed to direct patients to a specific pharmacy (i.e. show favoritism). One problem we ran into is that the Manitoba Pharmaceutical Association does not keep a list of retail pharmacies that have an IV hood so it is just through word of mouth that we are able to track these places down. If we do not tender, we may have to provide patients with a list of pharmacies that will provide this service. However, our preference is to deal with one pharmacy only.

*Please note that to receive these e-mails you must have checked "Yes" under "e-mail list" in your RPN website Account (www.renalpharmacists.net, then Login then click Account on left-hand side).

Member Profile – Marisa Battistella

Marisa has plunged full speed ahead into the Renal Pharmacists Network. She has just completed her term as Vice-Chair and is assuming the role of Chair in December. This coincides with her finishing her second maternity leave, so we know she will be fresh and full of vigour for the upcoming year.

Marisa is a U of T graduate from 1998. She completed her residency at Sunnybrook 1998-99. She worked until January 2002 in general medicine while concurrently completing her Pharm D via distance learning from Idaho State. She took time off between January 2002 until August 2002 to complete her rotations. Thereafter, she began her career in renal pharmacy at the University Health Network in Toronto.

When asked "What do you enjoy most about your job?" her response is "I enjoy the satisfaction of helping the patients with their medications. I also enjoy research and thus the work I do with the other health care people in HD."

The challenge of the job seems to be an issue for most of us. "Too much work in a good way! (too many patients to see to help sort out their medications)."

Marisa is a runner. She finds it a great stress reliever and break from life! She completed two marathons in 1998 and 2000. She also plays soccer (indoor and outdoor). She has 2 lovely little boys that she wishes she could spend more time with – and of course is married to a great guy who understands the profession of pharmacy well!

Good luck this year Marisa. RPN members look forward to your new ideas and leadership!

– L.S.

UPCOMING CONFERENCES

Canadian Society of Hospital Pharmacists Professional Practice Conference

January 28 - February 1, 2006
Westin Harbour Castle, Toronto, ON
www.cshp.ca

Annual Dialysis Conference

February 26 - 28, 2006
San Francisco, CA
www.muhealth.org/~dialysis

RPN Satellite Luncheon

February 1, 2006, 12:40 - 2:10pm
Westin Harbour Castle, Toronto, ON
Topic: Dyslipidemia in CKD
Speaker: Dr. Gary F. Lewis
University Health Network

CSN Annual Meeting

May 24 - 28, 2006
Loews Le Concorde Hotel, Quebec City, QC
www.csnscn.ca

European Society of Clinical Pharmacy

May 25 - 27, 2006
Vilnius, Lithuania
Chronic Disease Management:
The Role of the Pharmacist
www.associationhq.com/escp/baltic/defaultWin.htm

MEMBER NEWS

Congratulations to Reshma Rathod, Renal Pharmacist at Lakeridge Health in Whitby who was married on September 10, 2005 in Toronto, ON. Reshma and her husband Anil enjoyed a safari honeymoon in East Africa and are settling into married life.

Congratulations to Julie Scott, Renal Pharmacist at Grand River Hospital in Kitchener, ON on the birth of her daughter, Courtney Elizabeth, on October 1, 2005. Julie came to the hospital in the evening, had Courtney, who weighed in at 7 lbs 14 oz, and was home in bed by 2 in the morning thanks to a great midwife and relatively stress-free delivery! Mom, Dad and daughter are all doing well.

WEBSITES OF INTEREST

www.nephrologypharmacy.com
This is a U.S. site. Good handbooks and newsletters.

www.hopkins-abxguide.org
www.dobugsneeddrugs.org
Antibiotic sites (both have good tables for antibiotic coverage)

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.*

Check out the RPN Website at www.renalpharmacists.net on a regular basis for 2006 CE activities.

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