Hep C Marching forward!!

Hume Region

Chris Biesiekierski

2015

The new drugs arrived!!!

Commencement of 2016, the journey of all PBS-oral, short course, minimal side effect and 95% cure arrived.

At GV Health we treated as many patients in first 12 months as had been treated in the previous 5 years with Interferon/RBV.

2017-18

- Cream gone from the top of the pile
- Re-focussed role to a more community based
- Engaging with GPs, educating and supporting
- Offered education to all GPs within the immediate area
- Continue to provide Fibroscanning to patients in the region with a request

2018-19

- Refocussed attention to GP clinics in the wider community providing education and support

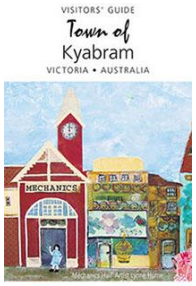
-Local town GPs targeted

-Local pharmacies targeted to encourage engagement

-Local small hospitals and health facilities targeted, Kyabram/Benalla/Yarrawonga

-Local rehabilitation facilities targeted

Example-Kyabram



Small town, rehab facility, 2 x GP Clinics, 2 x Pharmacies, small local public hospital, Emergency Dept/Specialist Consulting Suite.

- Provision of education to all nursing staff and any other interested staff (8 sessions provided)
- Established monthly clinic using NP (comm Feb)
- Educated local GPs (2 x separate sessions)
- Approached Pharmacies-one now on board

Post COVID-2022 Other townships targeted eg Cobram, Numurkah and Nathalia

Medical Clinics in Cobram already educated, hospital offered multiple education sessions.

Numurkah/Nathalia medical clinics, not yet targeted. Hospitals offered multiple education sessions.

There are a couple of other areas still to receive attention.

What is needed?-SURVEILLANCE

WHO?

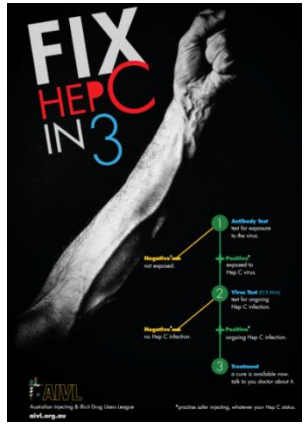
Table 1. Populations to consider for a hepatitis C virus (HCV) screening test

- People who inject drugs or who have ever injected drugs
- People in custodial settings
- People with tattoos or body piercing
- People who received a blood transfusion or organ transplant before 1990
- Children born to HCV-infected mothers
- Sexual partners of an HCV-infected person (individuals at higher risk of sexual transmission include men who have sex with men and people with HCV–HIV coinfection)
- People infected with human immunodeficiency virus or hepatitis B virus
- People with evidence of liver disease (persistently elevated alanine aminotransferase level)
- People who have had a needle-stick injury
- Migrants from high-prevalence regions (Egypt, Pakistan, Mediterranean and Eastern Europe, Africa and Asia)

WHICH TESTS?

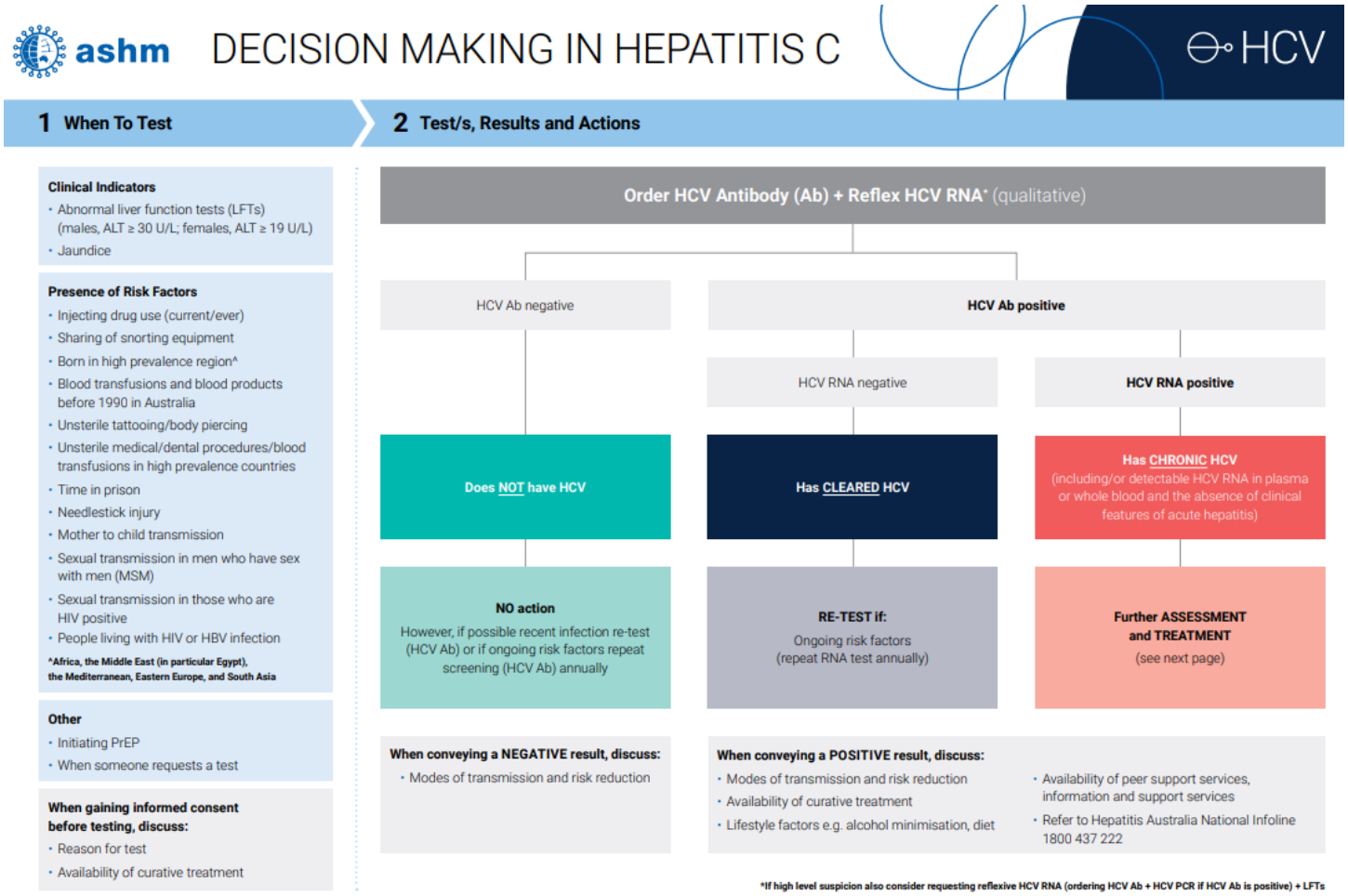
- In Notes section: Request general bloods- FBE/U & E/LFTs then specifically- HepC a/bs (antibodies) and then +/- HepC PCR or RNA
- Required check prior to commencement of treatment:Hepatitis B surface antigen (HBsAg), hepatitis B core antibody (HBcAb), hepatitis B surface antibody (HBsAb), HIV serology, hepatitis A serology.

Test results



- If the HepC a/bs return positive, a PCR/RNA needs to be completed to confirm their Hep C status
- If PCR/RNA positive PLEASE initiate treatment, obviously ensure the results of other tests completed are within normal limits

Summary of Screening



When to Refer Patients to a Specialist

- Patients with advanced fibrosis or cirrhosis
- Patients with extrahepatic manifestations
- Patients with complex co-morbidities
- Patients with renal impairment
- Patients with HIV/HCV or HBV/HIV coinfection
- Patients who failed first line DAA
- Patients for potential clinical trials of new HCV regimens

- BUT tertiary centres will continue to provide treatment for patients of all stages of fibrosis

Summary of Treatment

ashm DECISION MAKING IN HEPATITIS C — HCV

3 Pre-Treatment Assessment

Baseline screening after positive HCV PCR

- ☐ LFTs (including AST) and INR
- ☐ Full Blood Count
- ☐ Urea, electrolytes, creatinine

Assess liver fibrosis: cirrhotic status

- ☐ Signs of chronic liver disease (spider naevi, palmar erythema, jaundice, encephalopathy, hepatomegaly, splenomegaly, ascites, peripheral oedema)
- ☐ Non-invasive assessment of fibrosis:
  - Serum biomarkers such as APRI (<1.0 means cirrhosis unlikely). Calculator available hepatitisc.uw.edu/page/clinical-calculators/apri
  - Elastography assessment e.g. Fibroscan® (>12.5 kPa consistent with cirrhosis)

Check for other causes of liver disease

- ☐ Check for viral coinfection:
  - HIV Ab/Ag
  - Hepatitis A – check hep A IgG; vaccinate if negative
  - Hepatitis B – check HBsAg, anti-HBc and anti-HBs; vaccinate if all negative
- ☐ Heavy alcohol intake
- ☐ Fatty liver disease - check weight, BMI

Check for other major co-morbidities

- ☐ Renal impairment (eGFR < 50)

Review previous HCV treatment

- Choice/length of treatment may be influenced by prior HCV treatment experience/response

Consider pregnancy and contraception

- HCV treatment not recommended for use in pregnant or lactating women

4 Treatment

Recommendation for treatment now includes all people with a risk factor for hepatitis C transmission who are found to have detectable HCV RNA in plasma or whole blood, regardless of the duration of infection.

Is your patient likely to have cirrhosis?
(APRI ≥ 1.0 or Fibroscan® > 12.5 kPa)

- ☐ Yes → Discuss with or refer to a specialist#
- ☐ No

Has your patient received previous treatment for HCV?

- ☐ Yes → Discuss with or refer to a specialist#
- ☐ No

Treatment	Dosage	Duration if no cirrhosis present	Duration if compensated cirrhosis (Child Pugh A) present
SOF/VEL~ (Epclusa®)	400/100mg Once-daily (1 pill)	12 weeks	12 weeks
GLE/PIB~ (Maviret®)	100/40mg per pill Once-daily (3 pills)	8 weeks	8 weeks†

- ☐ Check for drug-drug interactions at hep-druginteractions.org
- ☐ Call the PBS Authority Script Line (1800 020 613) for approval

Consult with your local specialist or complete the online remote consultation form at reach-C.ashm.org.au (turn-around time <24 hours).

 # All patients with cirrhosis or prior HCV treatment experience should be reviewed by someone experienced in hepatitis C treatment. If cirrhosis is suspected (APRI ≥ 1.0 or elastography > 12.5 kPa), further evaluation is required before commencing treatment.

† A treatment duration of 12 weeks may be considered for patients with compensated cirrhosis at the discretion of the prescriber.

5 Monitoring

Monitoring while on treatment

- Generally not required but approach should be individualised
- Side effects of HCV treatment are generally minimal
- Dose interruptions should be managed according to duration and DAA therapy completed (Refer to Hepatitis C Consensus Statement)

4-12 weeks post treatment

- ☐ Opportunistic testing: HCV RNA to confirm cure (sustained virological response SVR4 = cure)
- ☐ LFTs

6 Follow Up

If your patient has no cirrhosis and normal LFT results (males, ALT< 30 U/L; females, ALT < 19 U/L) ALT = alanine aminotransferase

No clinical follow-up for HCV required

If your patient has ongoing risk factors

Annual HCV RNA test. If re-infected, offer re-treatment and harm reduction strategies

If your patient has abnormal LFT results

(males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L)
Evaluate for other causes of liver disease and refer to specialist for review

If your patient has cirrhosis

Refer to specialist. Patients with cirrhosis require long-term monitoring:

- 6-monthly abdominal ultrasound (hepatocellular carcinoma screening)
- Consideration of screening for oesophageal varices
- Osteoporosis: 2-yearly DEXA scans and monitor serum vitamin D
- Assess risk of clinically significant portal hypertension (elastography, PLT)

CONSULT WITH A SPECIALIST IF:

Pre-treatment

- Prior treatment failure of HCV treatment
- Cirrhosis is present or likely – APRI ≥1 and elastography score not available; elastography >12.5kPa
- Coinfected with HIV or HBV
- Renal impairment (eGFR < 50)
- Complex drug interactions
- Complex co-morbidities
- Not comfortable prescribing HCV treatment
- Paediatric populations

During treatment

- Major medication side events

Post-treatment

- RNA positive 12 weeks post treatment
- Abnormal LFTs at SVR12

Disclaimer: Guidance provided on this resource is based on guidelines and best-practices at the time of publication. This quick-reference guide is not intended to be a comprehensive list of all available options. Refer to the General Statement for Drugs for the Treatment of Hepatitis C for all current PBS-listed regimens.

For more information www.hepcguidelines.org.au

~SOF/VEL = Sofosbuvir/Velpatasvir ; GLE/PIB = Glecaprevir/Pibrentasvir

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Discussion