CONSENSUS STATEMENT: HEPATITIS C*

KEY MESSAGES

- The hepatitis C epidemic is a public health crisis.
- Services are already struggling to cope with the burden of infection and liver disease.
- Significant resources must urgently be directed at improving prevention and delivery of care.
- High priority for case finding should be given to former injecting drug users.
- Community-based and specialist nurse-led services should be provided.
- The requirement for liver biopsy to determine selection of patients for therapy is no longer essential for all patients.
- Access to treatment should be broadened to all those who might benefit.

1. WHAT IS THE NATURE OF THE PROBLEM?

1.1 Hepatitis C, a blood-borne virus affecting 200 million people worldwide, poses a significant and growing problem. Currently services do not have the capacity, nor are they configured appropriately, to meet the needs of the majority of infected individuals. Estimates suggest 300,000 – 600,000 people are infected in the UK. Most are unaware they are affected, and only a small fraction of patients who might benefit from antiviral therapy are currently being treated. An effective vaccine is unlikely to be developed in the near future.

1.2 Hepatitis C virus (HCV) can have serious physical, social and psychological consequences. Infected patients are a stigmatised group which may face social exclusion. Between 60% and 80% of affected individuals will become chronically infected, the majority of whom will develop liver inflammation, which may eventually lead to cirrhosis and liver cancer. HCV can also cause other problems that impair quality of life such as fatigue, joint pain, and neurocognitive impairment.

1.3 Treatment, although increasingly successful, is lengthy, complex to administer, expensive and associated with significant side effects. Disease progression is adversely affected by factors including alcohol consumption, obesity, age and co-infection with HIV or hepatitis B.

1.4 Injecting drug use is now the main route of acquiring infection in the UK. Other patients, such as haemophiliacs, contracted the virus from infected blood products or transfusions before current safety measures were introduced.

2. WHO IS AT RISK AND HOW DO WE IDENTIFY THEM?

2.1 The risk of acquiring HCV varies between different groups, and is greatest in injecting drug users (particularly those who continue to inject while in prison) and relates to sharing of any injecting paraphernalia. There is evidence of increasing incidence, particularly in young injectors, despite the initial success of harm minimisation measures.

2.2 There are potential benefits and disadvantages of more widespread testing; appropriate pre- and post-test discussion and support are essential. Benefits for the individual of a positive test may include alcohol reduction, hepatitis A and B immunisation, monitoring, and acceptance for treatment. The public health impact of testing is unclear and should be quantified. General population screening is not indicated.

2.3 Injecting drug users on an individual basis should be offered testing at a point agreed with their main health care professional. A high priority for case finding should be given to former injecting drug users, especially those over 40, who are likely to have a stage of disease which would benefit from treatment. Cost-effective methods of identifying this group, through public awareness initiatives, primary care, drug treatment services and prisons, should

*The Consensus Conference on Hepatitis C was held on 21–22 April 2004 at the Royal College of Physicians of Edinburgh.

be established. It must be faced that identifying more patients will mean increased demands and costs.

3. HOW SHOULD WE MANAGE THE PATIENT?

3.1 Management of patients with HCV is much wider than assessment for antiviral treatment and this provides significant challenges to health care services due to the scale of the epidemic and because most patients are asymptomatic and/or undiagnosed.

3.2 There are at least four patient groups, including those who are unaware they are infected, who have been tested and are suitable for treatment, who are not eligible for treatment, or those for whom treatment has failed.

3.3 Only half of those referred attend clinics, therefore services must be urgently re-thought to encourage involvement and patient views should be sought.

3.4 Effective engagement with the drug-injecting population is central to tackling the growing epidemic and managing those chronically infected. Poor compliance and non-attendance are major problems. Good quality, consistent information for patients and staff on the nature of the illness, management options, and local services is essential. An integrated service is vital and Managed Clinical Networks (MCN) could achieve this.

3.5 Prevention of transmission or disease progression is crucial. Primary care, drug treatment services, and specialist services should actively offer counselling, testing, sexual health advice, and harm reduction interventions such as needle exchange.

3.6 A new community-focused model of care is needed: outreach nurse-led clinics (in assessment, treatment and monitoring) in primary care, in prisons or with drug treatment services. Healthcare workers need training and GPs need clear guidelines concerning suitability for referral. Those who are not treated and chronically infected need ongoing monitoring and support. Potential barriers to treatment, such as current injecting drug use and mental health issues, need to be reconsidered.

4. WHAT IS THE BEST TREATMENT?

4.1 The primary aim of therapy for Hepatitis C is viral clearance. Sustained viral response (SVR) is defined as the absence of HCV RNA in serum 24 weeks after completion of therapy. The requirement for liver biopsy to determine selection of patients for therapy is no longer essential for all patients.

4.2 Combination therapy with pegylated interferon alfa and ribavirin is recommended for all patients suitable for therapy. There are six genotypes of HCV. Patients with genotypes 1 and 4-6 should receive therapy for 48 weeks and genotypes 2 and 3 for 24 weeks. In genotype 1, quantitative PCR (a test of viral load) at 12 weeks will determine if patients continue therapy. Treatment success in trials overall exceeds 50%, and is influenced by genotype, age, gender, stage of disease and compliance. Re-treatment is recommended for patients previously treated with Interferon monotherapy who have relapsed, but not those with primary non-response.

4.3 Patients should be supported throughout treatment because of the high frequency of side effects and the need for careful monitoring. Screening for complications such as hepatocellular cancer and oesophageal varices is recommended for patients with cirrhosis.

4.4 New drug therapies are urgently needed. The role of complementary therapies has not been established.

5. WHAT LIES AHEAD AND CAN WE AFFORD IT?

5.1 The incidence of HCV infection is increasing. Anti-viral treatment has so far had a relatively minor impact on the burden of disease and management of end-stage liver disease is expensive. Liver services are already over-stretched and the projected need for liver transplants will be impossible to meet. Prevention initiatives need to be expanded. Efficiency of the range of HCV services must be optimised, for example by reducing non-attendance, enhancing referral, improved data collection and, crucially, service audit within the framework of a well designed MCN.

5.2 Economic analysis should inform resource allocation decisions between competing demands both within HCV services and the wider healthcare setting. Many preventive and therapeutic HCV interventions are clearly cost-effective, but uncertainty surrounds the longer-term resource consequences and health outcomes of other strategies.

5.3 What is certain is that, if we do not invest adequately now, we will not be able to afford the consequences of failing to tackle this epidemic.