

Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting: <https://reachmd.com/programs/cme/hot-topics-in-hcv-a-multidisciplinary-online-minicurriculum-activity-1-treating-hepatitis-c-in-primary-care-you-can-you-should/12747/>

Released: 09/20/2021

Valid until: 09/20/2022

ReachMD

www.reachmd.com

info@reachmd.com

(866) 423-7849

Hot Topics in HCV: A Multidisciplinary Online Minicurriculum - Activity 1: Treating Hepatitis C in Primary Care? You Can! You Should!

Dr. Franco:

Welcome to Activity 1 in this three-part Hot Topics in HCV mini-curriculum, "Treating Hep C in Primary Care? You Can. You Should." I am Ricardo Franco, Associate Professor of Medicine in the School of Medicine, Division of Infectious Diseases, at the University of Alabama at Birmingham, in Birmingham, Alabama, and with me today is Dr. Chuck Vega. He is Clinical Professor in Family Medicine, and Director of the Program in Medical Education for the Latino Community – PRIME-LC. He is also Associate Dean at the University of California Irvine School of Medicine, in Irvine, California. Welcome, Dr. Vega.

Dr. Vega:

Alright, well thank you, Ricardo. It's great to be here.

Dr. Franco:

Wonderful, let's begin. Due to the opioid crisis, virtually all populations and regions are now impacted by the HCV epidemic. This has called for expansion of the HCV treater workforce, with a special emphasis on enlisting primary care providers to participate in HCV elimination efforts. Chuck, before we speak to the PCP's role, could you give us an overview of this need?

Dr. Vega:

Right, Ricardo. Thanks very much for this opportunity, because the need is profound, really. So, over four million adults in the United States have a positive test for HCV antibodies, and that may actually be as high as seven million, when you take into account that many of these folks are hard to count. They may be homeless, or they may have other reasons they are not in touch with the health care system. And then, over two million – 2.4 million, to be exact – have active hepatitis C infections. About 36% of new cases of HCV are discovered among this baby boomer generation, and I think, very importantly, they represent a disproportionate number of deaths due to hepatitis C, so very important group to consider. But, as this opioid crisis has continued and during the last couple years, particularly in response to the COVID-19 pandemic, it's actually worsened. Now we're seeing the majority of cases coming from use of opioids and other drugs, and the hepatitis C virus antibody prevalence among people who inject drugs is estimated to be as high as 70%. So one in three people who inject drugs will acquire hepatitis C infection in their first year. And unfortunately, this includes a special group that I think is worth highlighting, and that's women of reproductive age. So, it's been estimated that between 2000 and 2015, the national rate of hepatitis C infection among women giving birth increased over 400%. And, that's not just a risk for these women, but it's a risk for their offspring as well, because the vertical transmission rate for hepatitis C, just when it's an infection on its own, is nearly 6%, and then when there's a co-infection with HIV and hepatitis C, which is not an uncommon occurrence, that vertical transmission rate jumps to nearly 11%. So really, a public health crisis around hepatitis C, which is now a curable disease.

Dr. Franco:

Well said, Chuck. So you certainly have portrayed this tremendous need, so does PCP just jump in, in HCV care? Or are there supportive partners that they can rely on?

Dr. Vega:

So we're really seeing a decentralization, moving from the hospital setting into the outpatient setting, and into the primary care office. One thing that's been concerning is that the drugs used to treat hepatitis C previously, were fairly restricted in different states, regarding

who could prescribe them, that they really needed a specialist to prescribe them. Those requirements have largely come down across the United States, so these are treatments that are available to primary care, and that will be covered by medical insurance. And it's important to treat in primary care, because you really don't see a difference in terms of who's giving the drugs, when it comes to patient-centered outcomes, like a cure rate, a sustained viral response at 12 weeks. If you look at whether specialty offices are giving the antiviral drugs, primary care physicians are doing it, or nurse practitioners are doing it, the cure rates are about the same. We know that individuals who were treated in the primary care office versus a specialty office were more likely to begin treatment, and more likely to complete treatment and get that sustained viral response. So overall, I think it shows there's a great role, and in primary care, as we all know, every time you create an extra step for a patient – the patient has to leave your office and go to the lab, patient has to wait for an approval to go see a specialist to get the treatment for the hepatitis C – everyone, we lose people at every step. So why not try to consolidate those steps? Keep it in our offices, keep patients at their medical homes for this important treatment, and we'll have better results.

Dr. Franco:

But why aren't we seeing a better uptake of HCV care by PCPs at the moment?

Dr. Vega:

Well, it – that's a great question, Ricardo, thank you. I think there's a lot of historical reasons. Some PCPs just aren't aware that they can treat hepatitis C. They're not necessarily familiar with the guidelines regarding treatment, which is why programs like this are so wonderful. They may not have a lot of support within their particular health system. I think that has changed a lot. And there have been those historical barriers, either by insurance or maybe even by patients themselves, that make PCPs turn away from it. Why wouldn't we want to treat those patients, now that we have tools that I think are easy to understand, and we have treatment that's highly effective. So this is really a call to action to our colleagues.

Dr. Franco:

Well said. So let's turn our attention now to HCV screening. Chuck, would you please walk us through the CDC guidelines?

Dr. Vega:

Right. And these have been simplified a lot, and they've been, I think, made more relevant to a population that really is – overall, we as a country are at risk for hepatitis C. So we talked about some of those numbers, which are truly frightening, and that led the CDC to change the recommendations so that all individuals, 18 years and over, should be screened at least once for hepatitis C. And for individuals who are pregnant – women who are pregnant – they should be screened with each pregnancy as well. Now, of course, we have folks who have a higher risk for hepatitis C, and those individuals I'm screening more often, and so I think that that's important. And I think another good point is, anybody who comes in and requests a hepatitis C test, I always give it to them. Now, they may not be willing to share a lot about why they want the test, but the fact that they're there and asking for it – it doesn't happen a lot in my practice, but when it does, my ears definitely perk up, and I'm going to ask them about risky behaviors, and not only will I think about screening for hepatitis C, but those individuals, I'm usually thinking about HIV screening of course, hepatitis B screening, and possibly syphilis as well.

Dr. Franco:

What I like the most about making hepatitis C screening universal is that you basically destigmatize the screening process by itself, so that the only question that really matters is if you want to be screened, or if you agree to be screened, right? Now, some of our clinicians may need a refresher on HCV serologies, so if you could, walk us through the clinical interpretation of some key HCV diagnostic tests.

Dr. Vega:

So, the way we screen for hepatitis C in the United States is by using an anti-HCV antibody, and ideally that's paired with a test for HCV RNA, if the antibody test is positive. So, start with the antibody test. Now that can indicate a current infection, or it can indicate a past infection. Remember that a good percentage of individuals will clear an initial infection with hepatitis C, and that estimate varies. I've seen that the estimate was 25% in one metanalysis. It may be higher than that, but the majority of individuals infected with hepatitis C go on to develop more chronic infection, and that's going to be evident by having that HCV RNA. Ideally, for efficiency's sake, and with the patient's care in mind, a reflex test, where if the HCV antibody is positive, it goes right to automatically test a PCR for HCV RNA right away, and that way, you'll know whether it's a current infection or a past infection. The use of prompts in electronic medical records, or other decision support, is critical. If you really want to make changes stick and practice management, you need tech. Just relying on the human element only takes you so far. But if you have a good reminder system on your electronic medical record, and you're combining that with following the guidelines, you're going to get a lot of people screened. You're going to get some disease found, and you're going to be able to treat those patients and make them well again.

Dr. Franco:

It is really interesting when you look at evidence of these interventions in practices, and how effective they are. It's a great impact of streamlining things and making it part of the common practice. So, this is evidence-based medicine well applied, when it comes to screening. HCV treatment has greatly evolved too, so highly effective, direct acting antiviral therapies are now well-tolerated, with short treatment courses of either eight or twelve weeks, and the cure rates are greater than 95%. Treatment guidelines have evolved as well, and they're now simplified and streamlined. So what was the intent of this simplification?

Dr. Vega:

Well, you know, I'm honored that these guidelines are simplified, just for folks like me. So it's simplified so that we can use this treatment more readily, because it's still underutilized overall, when it's safe and very effective. So the idea is get more treaters and we'll take care of more patients with HCV, and reduce the spread overall of this infection. And so, who's eligible for that simplified treatment? It's folks who don't have decompensated cirrhosis and they've not previously been treated for hepatitis C. So those are folks I'm going to want to involve a specialist with. And so, if they had prior HCV treatment, if they have had a liver transplant, if they have a co-infection, with either hepatitis B or HIV, if they're pregnant – all those folks I'm going to want to manage with a specialist, as well as individuals with end stage renal disease. But the majority of patients, and certainly the ones that I'm screening for hepatitis C who otherwise maybe feel fine, and have an occult infection, the work-up is pretty straightforward. It's labs we do all the time, so getting a complete blood count, getting a hepatic function panel, and getting an estimated glomerular filtration rate – usually that's just done with a CBC and a comprehensive metabolic panel – you're going to get that initial quantitative hepatitis C viral load. You're going to do that before you start antiviral therapy. Genotyping is not necessary when you're using a pan-genotypic treatment regimen, and we'll go over the two choices there. And then we're going to also check for HIV and hepatitis B shortly before treatment, because again, if those infections are concomitant, it becomes a little bit more complicated. You can't go through the streamlined therapy. So as I mentioned earlier, it's also really important to consider the risk of hepatitis C among women at reproductive age, and so screening and treatment of women in that age range really can make a difference in their overall wellbeing, the wellbeing of their kids. So, really important, something we should all be invested in. That said, the agents that we use against hepatitis C can have negative effects on pregnancy, so before initiating treatment, we want to make sure that a serum pregnancy test is negative, and we also, of course, want to counsel patients on not becoming pregnant, and offering contraception during the treatment period. And there are some really simple to use tools – the APRI, or the FIB-4 calculators. These use demographic data and laboratory results, which are readily available, to estimate the risk of cirrhosis. So, make sure that you have those in your toolbox as well, when you're evaluating patients with hepatitis C. And then finally, before we initiate therapy, we want to make sure there's no drug-drug interaction, so we're going to do a medication reconciliation, and then we're going to really try to enlist the patient, tell them how important it is to stay on therapy, to let us know if they're having problems with treatment, so that they can complete either their eight or twelve week course and see it through. And then, of course, treatment is really important, and we have two preferred pan-genotypic regimens that are effective against hepatitis C. So there's glecaprevir with pibrentasvir is one, and the other is sofosbuvir plus velpatasvir. Both of them are highly effective – over 95% in terms of their response rate, and the treatment regimen is, at maximum, 12 weeks. And then, on-treatment monitoring is really more focused on adherence, so you certainly want to keep up with patients, using telehealth – this is a great time to use telehealth because I'm checking for side effects, I'm checking for barriers to adherence. But in terms of routine laboratory monitoring, for a simplified regimen with those pan-genotypic antiviral agents that I just described, don't need it. So, they don't need to be coming in to the laboratory routinely. Post-treatment, then we want to check for HCV RNA, and if they have a history of minimal fibrosis, that's really it. I will check again, in terms of checking for RNA levels, should they continue in any kind of risky behaviors, particularly, and then make that routine part of their care. It is different if they have a history of advanced fibrosis because their follow-up has to think about their risk of cirrhosis and complications, so they should be screened for hepatocellular carcinoma with ultrasound every six months. Also, they should undergo a baseline endoscopy, looking for varices and then managing those varices, if found, longitudinally.

Dr. Franco:

Thank you. You have covered a lot of territory. What do we see as our next steps, Chuck, in both encouraging and supporting our PCP colleagues in taking on the HCV care in their practices?

Dr. Vega:

Well, that's a great question regarding next steps, because to me, we're already there. The door is open, and we just have to walk through. I think it's clear we are dealing with a very common, chronic infection that has devastating consequences overall, and we have the opportunity to screen for it, which I think a lot of us in primary care are doing, and now we really got to take that next step and treat it in primary care as well. It's going to yield much better patient outcomes, and overall reduce the public health burden of hepatitis C broadly across this country.

Dr. Franco:

I agree, Chuck, that primary care providers are in great position to not only treat hepatitis C well, but do great patient selection, and do

this responsibly. Thank you very much for this great conversation.

Dr. Vega:

Alright, well, thank you, Ricardo. It was fun.

Dr. Franco:

And thank you to our viewers for joining us today for this program. For additional clinical resources, please visit exchange.cme.com/hearttopicsshcv, and remember to complete the post-test and evaluation form to claim your credit, and please be sure to view the other two activities in this Hot Topics in HCV mini-curriculum – “What the OB/GYN Provider Needs to Know,” and “The Impact of the COVID-19 Pandemic on Vulnerable Populations.” Thank you.