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Understanding the Growing Syndemic—Opioids, HCV, and HIV

Announcer:

Welcome to CME on ReachMD. This activity entitled *Understanding the Growing Syndemic of Opioids, HCV, and HIV*, is jointly provided by Global Education Group and Integritas Communications, and is supported by an independent educational grant from Gilead Sciences, Inc. Prior to beginning the activity, please be sure to review the faculty and the commercial support disclosure statements, as well as the learning objectives.

Dr. Flash:

In the past several years, many of the U.S. have been affected in some way in our clinical practice or personal lives by the opioid epidemic in our country. Much attention and resources are being given to halt its devastating consequences, but this crisis has also fueled the spread of another deadly disease, hepatitis C virus infection. For perspective on the startling trend of HCV cases among young people

who inject drugs and what clinicians can do about it. Dr. Don des Jarlais, a Professor in the College of Global Public Health at New York University, and Dr. Charlene Flash, medical director at Legacy Health at Houston, Texas, discuss the means to halt the spread of HCV among people who inject drugs.

Hello, and welcome to the CME program in which we will discuss the feasibility and effectiveness of treating people who inject drugs and are infected with hepatitis C. My name is Dr. Charlene Flash, and I am the Associate Chief Medical Officer at Legacy Community Health, as well as Clinical Assistant Professor at Baylor College of Medicine in Houston, Texas. I'm joined today by Dr. Don des Jarlais. He is Professor of Epidemiology, Social, and Behavioral Sciences at NYU in New York City. So nice to have you today.

Dr. des Jarlais:

It's nice to be here.

Dr. Flash:

Dr. des Jarlais, let me start us off by framing for our audience the problem that is at the heart of our discussion today; 2.6% of the U.S. population have injected drugs at some point during their lifetime. Although that sounds like a relatively small percentage, it actually represents more than 6 million people. When thinking about the prevalence of chronic hepatitis C infection, 39% of people who have injected drugs during the past 12 months have chronic hepatitis C infection. Now this is markedly different than the numbers for HIV, where amongst people who inject drugs in the United States, HIV is only an issue for 5%. The tools that we have to mitigate HIV transmission include things like the use of antiretroviral therapy to get people's viral loads under control. And in the setting of virologic suppression, what we know is that people are no longer infectious. The second arm of HIV prevention is pre-exposure prophylaxis, or PrEP, the use of one tablet once a day to protect people who are vulnerable to HIV from becoming infected. When we think about tools to mitigate HCV transmission, these also include medications, so curative, direct-acting antiviral therapy can be used as a preventive agent. It not only cures people, but it also protects them from infecting others, as well as syringe service programs. Can you please describe for us the shifting epidemic in the United States, and the trends as they both relate to both hepatitis C and HIV?

Dr. des Jarlais:

We're seeing very, very different trends in HIV and HCV. HIV, among people who inject drugs, is clearly declining over time. It varies from region to region, but we clearly are doing a very good job of getting HIV under control among people who inject drugs. In contrast, the rates for hepatitis C are demonstrably increasing, particularly in Appalachia, up through the Northeastern part of the U.S., but also on the West Coast. So, while we've done a reasonably good job of trying to get HIV under control,

we really have not gotten started for controlling HCV in the U.S. One of the big problems with controlling HCV is that people tend to get infected very, very quickly after they start injecting drugs. Basically, about half the people who start injecting drugs are infected by the time they've been injecting for five years. So typically they become infected before they start using services like syringe services programs or medication-assisted treatment. So the big problem is getting to them before they become infected.

Dr. Flash:

Can you tell me a little bit about medication-assisted treatment? What is that?

Dr. des Jarlais:

Medication-assisted treatment refers to methadone and buprenorphine for treating opioid use disorders. They're by far the most effective medications we have for treating any substance use disorder. They are not curative, but they manage the problem really quite well. And even though they're somewhat stigmatized in the U.S., we should really be expanding those types of treatment for opioid use disorders.

Dr. Flash:

Let's turn our focus on, what do we do once chronic hepatitis C infection has been diagnosed in a person who injects drugs? I know you've been involved in some fascinating research in this area.

Dr. des Jarlais:

Our results from mathematical modeling show that syringe access programs and medication-assisted treatment by themselves have relatively modest effects on hepatitis C prevalence. That if we're going to deal with hepatitis C as an epidemic, we're going to have to do treatment with the direct-acting antivirals on a very, very large scale. The DAAs can both cure hepatitis C and prevent advanced liver disease, including death from advanced liver disease. But the cure rates or the SVR12, is the same viral response at 12 weeks post treatment, among people who inject drugs are excellent over 90% cure rates. You get essentially identical cure rates among people on opioid substitution treatment or medication-assisted treatment as people who are not on medication-assisted treatment. And you even get the same very high cure rates among people who are continuing to inject drugs.

Dr. Flash:

We've seen that direct-acting antivirals can achieve sustained virologic suppression for these patients. But what, in your view, are the large-scale hurdles that we'll have to overcome to eliminate hepatitis C amongst this population of people who inject drugs?

Dr. des Jarlais:

First, we need to think in terms of curing individuals; taking people with hepatitis C infection, curing their infection, and preventing them from dying from hepatitis C infection. That is obviously very, very important. But curing individuals is not the same as doing treatment as prevention as eliminating hepatitis C at a population level. We need to do a lot more treatment with the DAAs if we're going to control hepatitis C as an epidemic. That means we'll also have to do behavioral research to reduce the transmission behaviors, particularly people who are infected with hepatitis C, passing on their used needles and syringes to others. And we're also going to have to develop more interventions to reduce initiation into injecting drugs. As long as we have many, many more people starting to inject, we're basically trying to swim upstream against a very strong current and we just need to reduce that high-risk group of people who are injecting, keep people from starting to inject if we want to deal with the hepatitis C epidemic.

Dr. Flash:

So it sounds like the important features that we need to further research – resource and research, are reducing the initiation of injecting drugs and decreasing other transmission behaviors, and utilizing medication. What would you say are some of the barriers to initiating antiviral or DAAs in this population?

Dr. des Jarlais:

One of the barriers is that we're not doing enough testing for hepatitis C. There is a relatively simple test that can be done on fingersticks. There's an oral test. You then have to do a second test to determine if the person is infected with hepatitis C. The initial antibody test just tells you whether they've been exposed to the virus; it does not tell you whether they're currently actively infected. So we need to do a lot of screening for hepatitis C and we also need to do a lot of screening for drug use because if we don't screen for drug use, we're going to miss people who, if they don't have hepatitis C now, are at risk for becoming infected with hepatitis C. Then if we're going to deal with this as an epidemic, we need to treat people with hepatitis C, treat people who use drugs with dignity and respect. That we cannot expect to have good provider-patient relationships unless we can reduce the stigmatization of drug use that is unfortunately so prevalent in society and also in our medical system. And finally, we need to address misinformation about hepatitis C treatment. The old treatments before the direct-acting antivirals had very, very unpleasant side effect, so people basically did not want to use those treatments. There is still misinformation about hepatitis C treatment in the population of people who inject drugs. So providers need to be able to explain the new DAA treatments are very, very different from the old ribavirin treatments.

Dr. Flash:

So it sounds like much as was the case in the early days of the HIV epidemic when medications were

much more challenging to tolerate, that hepatitis C has experienced that, as well, where that movement to much more readily tolerated medications is a surprise to patient and provider alike. Now, are there some barriers to actually accessing medication or to get linked to care?

Dr. des Jarlais:

There are tremendous barriers to accessing the medication. It's currently expensive. Hopefully it will continue to be reduced in price over time. It is covered by some insurance programs, and not covered by others. And to establish that your insurance covers hepatitis C treatment can require a considerable amount of work by the providers or the provider staff, filing initial application. And if that gets turned down, you need to refile and such. If we were being serious about hepatitis C elimination, we would do things like what states like Louisiana have done. They made an agreement with the pharmaceutical companies that they will pay a certain amount of money per year, and then pharmaceutical companies will give them all the medication they need with minimal bureaucratic hassle to access the medication. So we need to think of new treatment payment models if we're going to reduce hepatitis C. Our current overly complicated health insurance medical bureaucracy in the U.S. greatly reduces our chances of curing hepatitis C.

Dr. Flash:

It's always fascinating how you have the tool, the medication, but it's the structural solutions that are needed to get it into the hands of the patients.

Dr. des Jarlais:

Yes, we've done a fairly good job of reducing those structural problems for HIV, and now we need to do the same for hepatitis C.

Dr. Flash:

So what about actually linking to treatment providers? How easy is that?

Dr. des Jarlais:

Yeah. If you're a provider and you don't feel confident that you can treat hepatitis C yourself, you need to develop good linkages with providers who can. And ideally that should include having patient navigators who can help a person with hepatitis C navigate the systems, obtain insurance coverage, help with setting up appointments, and help with keeping appointments, and adhering to the medication. And providers should also consider learning how to treat hepatitis C themselves. For uncomplicated cases, particularly in young people who don't have a lot of comorbidities, treating hepatitis C is not that difficult. One of the particularly challenging things about treating hepatitis C is that a lot of the new cases of hepatitis C are occurring in rural areas, where we don't have good health coverage at all, and particularly do not have many people trained in treating hepatitis C. So some of

the things that are being done to try to bring more hepatitis C treatment include telemedicine, where you have a linkage between the rural place where the patient is actually seen, and a hepatologist in a major medical center. And we've gotten fairly good results with that. We need to expand that. Healthcare in rural areas is under severe stress anyway, and a lot of the new hepatitis C epidemic, opioid use epidemic, is occurring in rural areas. So that's another issue that we need to really address if we're going to control hepatitis C infection.

Dr. Flash:

It's always challenging to have a challenge in an area where we're not well resourced with the solutions.

Dr. des Jarlais:

Yes.

Dr. Flash:

So, telemedicine is a wonderful option to help with that challenge.

Dr. des Jarlais:

Yeah, it's something that we're going to have to scale up if we're going to deal with hepatitis C in rural areas, and also deal with other problems – health problems in rural areas.

Dr. Flash:

So, in thinking about what we've discussed, we've talked about the landscape of hepatitis C infection amongst the population of people who inject drugs and the importance of testing, enhanced preventive efforts, and treatment, if you had to say there are two primary takeaways from all that we've discussed, what might those be?

Dr. des Jarlais:

First, that we're currently experiencing an epidemic of injecting drug use with hepatitis C infection, and with fatal drug overdoses; that is probably the number one public health problem in the country at this time. And we need to address all aspects of that at the same time, including reducing people starting to inject drugs, but curing hepatitis C among people who have started to inject drugs and who have become infected. Second, we now have the tools to address hepatitis C infection. We have prevention programs like syringe service programs, medication-assisted treatment for opioid use disorders, and we have excellent drugs for curing hepatitis C infection.

Dr. Flash:

Thank you, Dr. des Jarlais. This has been a very informative discussion.

And thank you for joining us for this CME program. We hope that what you've learned today will help you in your own clinical practice. For additional CME opportunities, clinical resources, and links to patient education materials, please visit us at www.exchangeCME. Please remember to complete the CME posttest and the evaluation. And thank you.

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