Transcript Details
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Addressing Treatment Challenges in Hepatitis C

Dr. Buch:
In the United States, between 2.4 and 4.7 million people have hepatitis C. While some patients lack access to treatment, many may not know they have this illness. So how can we help them get the proper care?

Welcome to *GI Insights* on ReachMD. I'm your host, Dr. Peter Buch. And joining me today to enhance our understanding of hepatitis C is returning guest Dr. Paul Kwo. Dr. Kwo is a professor of medicine and the director of hepatology at Stanford University, and he is passionate about getting the word out on hepatitis C.

Dr. Kwo, welcome back to the program.

Dr. Kwo:
Thank you very much. It's good to be back.

Dr. Buch:
To begin, Dr. Kwo, how should we approach a patient with hepatitis C who has an interruption in their treatment?

Dr. Kwo:
It's a very excellent and practical question. And, Dr. Buch, one of the important aspects of hepatitis C treatment is that we tell our patient if you take the duration of medicines for the prescribed duration, which is eight to 12 weeks, cure is expected. But people do miss doses. We all do. But in general, the DAA, or direct-acting antiviral medicines, that we give actually are so robust. If you've missed less than seven days, particularly in the first month of therapy, then what you do is you just continue the therapy; you resume, and in general, the missed doses less than a week will not compromise your opportunity for cure. You should get the same greater than 95 percent cure rate. If you miss more than that, particularly in the first month, then you should restart the therapies immediately, and then you can test for hepatitis C as soon as is feasible. If it's still undetected, which it often is, then you just complete your regularly prescribed duration of treatment, which is usually again, eight or 12 weeks. If, on the other hand, you have one of the what we call harder-to-treat hepatitis C cases, there is one type of hepatitis C genotype 3 or cirrhosis you may want to just extend the treatment for an extra four weeks, and then you will generally go on to cure. And then finally, of course, if your hepatitis C is positive when you have it checked, then just extend out the duration of the hepatitis C treatment for another four weeks.

If you've missed more than up to three weeks of therapy, then you need to check an HCV RNA, and if it's positive or detected, then you just need to stop treatment at that point after the first month, and then just retreat. This person is someone who's a treatment failure, just recognizing that you would also have to, perhaps, address any issues that interfered with the individual's ability to take the medicines consistently. And if again, is undetected, you just add on another four weeks, as we did in the first month. In general, if you use these measures, you still get to the same high cure rates that we've experienced for the last eight years with our direct-acting antiviral agents.

Dr. Buch:
Thank you so much. I'm sure that's going to be very useful for lots of audience members out there. And the next question is who

should be treated for acute hepatitis C?

Dr. Kwo:
The number of cases of hepatitis C still are not falling, and because of the opiate epidemic, acute hepatitis C is on the rise, particularly in those in the ages of 20-39. And oftentimes, it is at this time when they develop signs or symptoms of acute hepatitis that they engage in health care, and it is then that they should initiate treatment in this particular case immediately. This is an opportunity for somebody perhaps oftentimes, not engaged in the healthcare system, and they come in and they're evaluated. And typically, when we see acute hepatitis C, we confirm that hepatitis C is causing the acute hepatitis, and we immediately refer to treatment for these individuals, and if you treat acute hepatitis C, just like with the chronic hepatitis C, the cure rates are essentially 100 percent. And this is one model that can be used in the future to help in our hepatitis C elimination efforts.

Dr. Buch:
Dr. Kwo, what should we know about patients who have concomitant hepatitis B and C?

Dr. Kwo:
Yeah. So hepatitis B is actually the most common type of viral hepatitis worldwide, more so than hepatitis C. But as you indicated, we do see these individuals who present with both infections. It's not common. It's just a few percent, but it certainly happens.

When we see these individuals, what we do is we make sure that we've assessed their viral levels. And then what we try to do is we look and see which virus we think is, if you will, causing the dominant clinical presentation. So for instance, if the hepatitis B level is high and the ALT is elevated, the first thing we're going to do is we're going to put these individuals on suppressive therapy for hepatitis B. And the therapies we have for hepatitis B, unlike hepatitis C, are suppressive. You can't cure, but the therapies we have are excellent. And so we typically suppress the hepatitis B immediately if they have active infection with elevated hepatitis B levels, and then we move forward with initiating treatment for cure for the hepatitis C.

It gets a little bit more complicated if the hepatitis B levels are very, very low, what we call inactive hepatitis B because there is a small but a notable risk that the hepatitis B can actually reactivate, and so it's actually very easy in these individuals who have very mild hepatitis B. They just need to go on a hepatitis B treatment for just a brief period of time during hepatitis C treatment, and that will keep them out of trouble. But the hepatitis C cure rates in those who have hepatitis B are the same excellent greater-than 95 percent cure rates that we see without hepatitis B. And again, it's an opportunity if they have both infections that are active with high hepatitis B levels to engage these individuals and make sure they get on suppressive, appropriate therapy for hepatitis B in addition to curing their hepatitis C.

Dr. Buch:
Thank you. Changing directions a little bit, should direct-acting antivirals be given to patients with hepatocellular carcinoma?

Dr. Kwo:
So this is an excellent question and one that was initially, when direct-acting antiviral agents were introduced, a bit controversial. The hepatitis C direct-acting antiviral agents; one of their advantages is that you can give these medicines to very sick people, and we could not do that previously with our interferon-based therapies a decade ago. And so initially, there was some concern that hepatitis C treatment would change the biologic behavior of the hepatocellular cancer presentation in those who present with viral hepatitis C and hepatocellular cancer. However, we now know using larger well-controlled studies that actually if you treat hepatitis C with patients who have hepatocellular carcinoma, that the outcomes are as good if not better than not treating hepatitis C.

However, you should prioritize, and what I mean by that is that in general the liver cancer, that is hepatocellular carcinoma, that's a life-limiting disease, and so these individuals should have their hepatocellular cancer treated first, and then it depends on the clinical situation you're presented with. If these individuals have liver cancer and it's an early stage, you cure it, and then after you've ensured that the hepatocellular cancer is cured, then you can easily treat the hepatitis C with our direct-acting antiviral agents. And again, you'll get outstanding cure rates, the same that we get with all of our other populations that we treat.

Dr. Buch:
Thanks for that insight. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Paul Kwo about hepatitis C treatment.

So, Dr. Kwo, does a noncirrhotic patient who successfully underwent hepatitis C treatment need any follow-up?

Dr. Kwo:
So for patients who have no cirrhosis, these individuals require no follow-up with a couple of caveats. Number one, their liver tests need to also normalize. And, Dr. Buch, this means the AST level and the ALT level. If these are normal and your assessment was they did not have cirrhosis, then these individuals do not require any monitoring. However, if these individuals are still at risk for hepatitis C again, that is they have a substance use disorder, then these individuals should get annual testing for hepatitis C, just to make sure because certainly, once you're cured of hepatitis C, you can reinfect yourself. With regard to the assessment of cirrhosis, if you have cirrhosis, then you need to continue to screen these individuals for liver cancer.

And an important caveat in the noncirrhotic patient that we cure, which is the majority of patients with hepatitis C, is that you really have to be certain that these individuals don't have cirrhosis, and for me, that means that I'm assessing the fibrosis by multiple different methods. That is on imaging the liver looks okay; there isn't a low platelet count that makes me worried they have advanced liver disease. If any of these features are there, we continue to bring these people back to monitor for the development of liver cancer. Again, they're going to be cured of their hepatitis C.

Dr. Buch:
Thank you for that. What strategies can clinicians use to reach more people in the community who have hepatitis C?

Dr. Kwo:
So the strategies that we are going to need to pursue to reach more people to eliminate hepatitis C are really related to bringing the treatment of hepatitis C to our patients, and this means that we need to decentralize our treatment. So historically, for the last 15 years, how was hepatitis C treated? Well, somebody gets screened. You have an elevated liver test on a liver panel, and a primary care physician will refer to someone like myself. What we are going to have to do is to bring hepatitis C care to the community, and this means we need more telehealth, we need more community outreach, we need mobile units, and we need to make sure that we can bring the hepatitis C treatment to these individuals such that when they are seen in, say, a sexual health clinic or a clinic that does opiate substitution or primary care, that they are evaluated there, and the hepatitis C treatment is actually administered there. And particularly in the COVID era where we have such a higher rate of opiate use disorder, for instance, embedding these services and, for instance, syringe programs or other community health centers will allow us to identify, link to care, and immediately get these individuals treated. This, by the way, for hepatitis C elimination also means going into the prisons where there is a large population of individuals with chronic hepatitis C, and also represents an opportunity for us to eliminate hepatitis C in the U.S. And for that matter, the same strategy can be used worldwide.

Dr. Buch:
This was an excellent review on hepatitis C. I want to thank my guest, Dr. Paul Kwo, for sharing his insights.

Dr. Kwo, thanks so very much for joining us today.

Dr. Kwo:
And thank you very much for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening and see you next time