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How We Can Help Patients Navigate the Hepatitis C Care Journey

Dr. Buch:
Two to four million Americans are living with hepatitis C, but more than half of these patients don't know they even have it. So what do we need to know to help them navigate their care journey?

This is *GI Insights* on ReachMD. I'm your host Dr. Peter Buch. Here to discuss hepatitis C is Dr. Colin Swales, a hepatologist who is the Assistant Medical Director of Transplant Services at Harvard Hospital. Dr. Swales, thanks so very much for joining us here today.

Dr. Swales:
Thanks, Peter. It's good to be with you.

Dr. Buch:
Let's get started. Many practitioners are confused about how to follow hepatitis C patients who have spontaneously recovered. Can you please clarify that for us, Dr. Swales?

Dr. Swales:
Sure. So just to define what we're talking about, Peter, we're talking about patients who have been exposed to hepatitis C, who spontaneously clear the virus, correct?

Dr. Buch:
That is correct.

Dr. Swales:
Well, so they're the lucky ones. We assume there is about 15% of people who get exposed to hepatitis C who can spontaneously clear the infection. There's an interesting phenomenon where people who present with acute hepatitis C and by that I mean they have a lot of symptoms, they're jaundiced, most people do not have symptoms when they contract the infection. But if they do show up with symptoms, interestingly the clearance rate is higher. And so in some series, about even half of those patients will spontaneously clear that infection. But the bottom line is that if their viral load goes all the way to 0, and of course, they'll always be antibody positive, then they're considered to be cured. We know that people who have a sustained biological response to treatment or a viral load that goes to 0, they have a durable response and they don't after long periods of follow-up come back with viremia for some reason.

So what I would say to that is those people should be considered to have healthy livers, unless they have something else going on and they should be followed and given advice like every other patient.

The only thing I would add though is that there was a risk behavior that exposed in hepatitis C and they can get reinfected, and so it's an opportunity to counsel them about their risky behavior and how to mitigate that risk.

Dr. Buch:
And specifically, the risky behavior is shared needles, correct?

Dr. Swales:
Sure, shared needles, nasal cocaine; those are the two most common ways in the United States.

Dr. Buch:
Let's move on to this one. What would your advice be for the following scenario? There's two parts to this. A monogamous, heterosexual couple, one partner has hepatitis C.

Dr. Swales:
Really common question I get from my patients. And the issue here is that the hepatitis C-infected patient, or partner, could infect the other partner and obviously they don't want to do that. And so the question is: do they need to wear protection when having sexual contact? You can get hepatitis C through sex, but it's very rare. So we have some observational data to drive this advice, and the advice specifically coming from the CDC recommending that monogamous couples who have no other risk factors for STDs, in other words, not multiple sexual partners, other sexually transmitted diseases, that kind of thing, they have a less than 3% chance of transmitting that infection over a 40-year relationship. So the CDC recommends that they don't take any special precautions, no barrier protection. However, it is an opportunity to leverage the situation into convincing the hepatitis C-infected patient to get treated because even though the risk is low, there is more at stake than just his health or her health.

So the short answer is they don't need to take any special precautions unless there are other risk factors.

Dr. Buch:
And the other member of the couple?

Dr. Swales:
This is the person who is not hepatitis C-infected, right?

Dr. Buch:
Yes, the person who is not hepatitis C-infected.

Dr. Swales:
Right, so they don't need to take any special precautions. There's the general advice for hepatitis C-infected patients that they don't share personal hygiene items like razor blades and toothbrushes, so I might remind them to do that.

Question I get a lot is: is there a vaccine? And there is not. There has not been developed a vaccine or any passive immunity for hepatitis C that has efficacy and so that is not an option like it is for hepatitis B.

Dr. Buch:
Perfect. And what would you recommend for a hepatitis C patient with cirrhosis who is "cured" of the hepatitis C?

Dr. Swales:
The official definition of a cure is a sustained virological response, that is a viral load or a molecular test that goes to 0 after receiving treatment. And we know now from the interferon days that a sustained virologic response is durable. So if you follow people for many years, you know, decades into the future, they don't ever develop viremia again. Occasionally people will become viremic again, but it's generally thought that those patients are getting reinfected, so it's the point we made before, but is worth mentioning again that hepatitis C antibodies are not neutralizing and so even though you were successfully treated, you could get reinfected if you get exposed again. That said, if you get a sustained virologic response for treatment, you are good to go. We think that you don't progress any further. And so the stage that you were at will stay stable or may even revert, some people believe that fibrosis can revert, that's probably true for people who are earlier on in stage, you know, the stage 1, 2, 3 patients, more than the cirrhotics. But at the very least, they will stay stable over a long period of time. And so that is a good thing. That's the goal of the treatment.

Dr. Buch:
And specifically for a cirrhotic patient, what would be a recommendation with regard to ultrasound and perhaps alpha-fetoprotein?

Dr. Swales:
Yeah, so thanks for mentioning that. That's a special situation because we don't generally believe that the cirrhosis goes away and the cirrhosis remains a risk factor for liver cancer. And so even though they were successfully cured, they need to continue their surveillance for liver cancer and the data for that are pretty clear. So there was a follow-up on a trial that is a very old trial now called HALT-C looking at interferon, as opposed to our experienced patients who did or did not sustain an SVR and they were followed for a long period of time after treatment. And the patients who were successfully cleared, and by the way, this data has been replicated now in the direct-acting antiviral treated patients, they do better than patients who didn't, for sure. You had about at 75% relative risk reduction for liver cancer decompensation for cirrhosis. But a few of them every year in the HALT-C series would get sick. They would either decompensate or they would get liver cancer. Mainly they would get liver cancer at about a rate of, if I remember correctly, maybe about 0.5% or a % per year. And that percent is advised that they continue to receive hepatoma surveillance, moving forward. And, by the way, screening for luminal portal hypertension, if they haven't done that.

Dr. Buch:
And what's your feeling about alpha-fetoprotein?

Dr. Swales:
So, controversial. It always has been, and I think it always will be. That said, I'll divide my comments into two sections. One is to say that the guidelines don't recommend alpha-fetoprotein monitoring. And so if you're strictly on guideline, the AASLD or the multi-sited guidelines of the United States, you don't need to do it, but pretty much every hepatologist that I know does it. And I do it and the reason for that is that if you take allcomers, alpha-fetoprotein doesn't perform very well and probably in part that is because half of the patients who develop HCC, they don't monitor alpha-fetoprotein;, their tumors don't excrete it or whatever the biology is, they don't make it. And so you're gonna have poor performance on half the patients for that reason.

And the other reason is that the alpha-fetoprotein can be a little bit finicking. You know, it can be mildly elevated in people who don't have an HCC and it's more useful to follow whether or not the alpha-fetoproteins trajectory is changing. In other words, the rising or, you know, bumping up even to a low degree that's more useful than the absolute number. So for those reasons, it's just not a clean test. It's certainly not a stand-alone test but we've all had patients who they bump their alpha-fetoprotein and that's the only clue we have that something might be brewing, and it forces us to look harder.

Dr. Buch:
Very insightful. I appreciate that. For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch and today, I'm speaking with Dr. Colin Swales about hepatitis C.

So, let's move on. Dr. Swales, how do you match a hepatitis C therapy to a patient?

Dr. Swales:
This portion of the treatment has changed the most. But we've reached a new equilibrium now with the direct acting anti-viral agents. And so, the choice as to who to treat has become much easier. Almost anybody can tolerate therapy without side effects, and we don't need to worry about harms that are caused by therapy nearly as much as we used to. The main driver of how to choose the treatment is generally who is paying for it. And so if the insurance company or the payer has a preferred treatment on formulary, that generally drives the prescription.

Dr. Buch:
We're gonna talk now about some important extra-hepatic complications of hepatitis C. Can you elaborate on that for the audience?

Dr. Swales:
Sure. So there are a raft of them. Most of them are rare. The one that's worth spending a little time talking about, I think, is the vasculitis component, so the cryoglobulinemia and/or the, the renal injury that comes from hepatitis C. And so, it's well known now that hepatitis C causes several kinds of glomerular injury and that obviously is risk factor of chronic kidney disease. The two most important ones to know about are membranoproliferative glomerulo, nephritis, and the IgA-type nephropathy and we believe that treatment of hepatitis C can improve both of those. And that's one of the strongest arguments to try to treat people regardless of whether or not they are advanced in stage is that there are hepatic manifestations. Some people speculate that diabetes is potentiated or even triggered by hepatitis C, I think that's a little more controversial. And then there are a raft of rare things like lymphomas that can be associated with hep C infection and I think more of an argument to try to get rid of hepatitis C, it's a bad, it's a bad bug to try to get rid of it if the patient's in a position to do that.

Dr. Buch:
Before we conclude, Dr. Swales, any message you want to share with our audience?

Dr. Swales:
Well I would say the chief challenge I think for us in American healthcare is just trying to get people diagnosed. Once, once you get somebody who tests positive for hepatitis C then every system pretty much has a pathway to try to get them accommodated and in for treatment. So I would think about it. It's easy to send an antibody and the CDC and the USPSTF I believe are recommending that everybody be screened, regardless of risk factors at this point and regardless of age. Grabbing an antibody could be an important way for you to make a huge difference in a person's health.

Dr. Buch:
Thank you, so much. Well, that brings us to the end of this program. I want to thank you, Dr. Swales for joining me today.

Dr. Swales:
Thank you, Peter, it's been a pleasure.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this program, as well as others from our series, visit ReachMD.com/GIInsights, where you

can Be Part of the Knowledge. Thanks for joining us today. Looking forward to learning with you soon.