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## Uncovering Unmet Needs in Hepatitis Management

### Announcer:

You're listening to *GI Insights* on ReachMD, and this episode is sponsored by Siemens Healthineers. Here's your host, Dr. Charles Turck.

### Dr. Turck:

This is *GI Insights* on ReachMD. I'm Dr. Charles Turck, and joining me to help uncover unmet needs in the management of hepatitis is Dr. Paul Kwo, who is a Professor of Medicine and Director of Hepatology at Stanford University. Dr. Kwo, welcome to you.

### Dr. Kwo:

Thanks for having me.

### Dr. Turck:

So if we start with some background, Dr. Kwo, would you summarize what we know about the prevalence of chronic hepatitis B and C?

### Dr. Kwo:

So hepatitis B is the most prevalent of the hepatitis viruses worldwide, and it's one where two billion people have been exposed to hepatitis B worldwide, and currently it's estimated there's somewhere between 250-275 million individuals who have chronic hepatitis B – that is, they are surface antigen carriers – worldwide. In the United States, it's been a bit more challenging to exactly quantify the amount of hepatitis B, and hepatitis B is the leading cause of liver cancer and liver deaths worldwide. In the United States, because this is a disease that may be more prevalent in individuals who immigrated to the United States, the estimates for hepatitis B are somewhere between 800 to 900 thousand and 2 million individuals who have chronic hepatitis B, and a substantial portion, as we can go into, are not aware that they have chronic hepatitis B.

The other chronic viral hepatitis infection that we have worldwide with high prevalence is hepatitis C, and like hepatitis B, this is also a blood-borne infection. This is a disorder, and right now, probably around 58 million individuals – it's estimated by the World Health Organization – are chronically infected.

### Dr. Turck:

So given the prevalence of those diseases, how are we doing in terms of detecting and diagnosing infections?

### Dr. Kwo:

Yeah. So this is something that has been somewhat challenging to get precise data, but in general for hepatitis B – again, let's talk with hepatitis B first – so for hepatitis B right now in the United States, the prevalence is actually increasing. Part of this is related to the injection drug use epidemic, and so in the United States, as I said, it's been estimated anywhere from 800,000, maybe as much as 2 million individuals. However at least according to CDC data, probably two-thirds of these individuals may not be aware of their infection.

Transitioning now to hepatitis C, we have similar challenges with hepatitis C as well. So it's been estimated there may be up to 2 million individuals in the US that are infected with hepatitis C, and hepatitis C epidemiology is changing. So back in the 1980s and 90s, this was thought to be a disease of the so-called baby boomer generation – those born between 1945 and 1965 – but we've had this shift now, and the highest prevalent group with hepatitis C are now those individuals who are ages 20 to 39, and then, of course, our older individuals ages 55 to 70 still do have a higher prevalence of hepatitis C, and so we have much work to do now.

### Dr. Turck:

And how can a delayed diagnosis impact our patients?

**Dr. Kwo:**

Hepatitis B and hepatitis C are silent diagnoses. That is these individuals are infected, but most of the individuals who are infected don't have signs or symptoms of hepatitis, so there are several unfortunate sequelae that occur because of this. So number one, you can get progressive liver damage, and hepatitis C and hepatitis B in combination with other common liver diseases that we are now seeing can accelerate the fibrosis and damage to the liver. So we have also substantial health concerns with fatty liver disease. We also have had an unfortunate increase in the prevalence of alcohol-related fatty liver disease as well. So all of these diseases can, if you will, contribute to substantial liver damage, and again, most of the time these individuals are without signs or symptoms.

**Dr. Turck:**

For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Charles Turck, and I'm speaking with Dr. Paul Kwo about unmet needs in the hepatitis care continuum.

So, Dr. Kwo, if we turn our attention to how we can improve the management of these patients, would you walk us through the CDC screening recommendations we should be implementing in practice?

**Dr. Kwo:**

The CDC recently updated their recommendations for hepatitis B screening in a way that many of us really thought was a very beneficial policy change, and that is that they have now recommended that all adults age 18 years and older be screened at least once in their lifetime for hepatitis B. It's a triple panel test with a surface antigen as well as a hepatitis B surface antibody and hepatitis B core antibody as well, and this allows individuals to be identified with chronic hepatitis B. It allows us to identify those individuals who are requiring vaccination for hepatitis B and also those who have been exposed to hepatitis B, and why that's important is because hepatitis B, even if you've cleared hepatitis B, you can also reactivate, and so this triple panel testing is really, I think, going to improve outcomes and identify more individuals who are chronically infected, and we should be able to hopefully link these individuals to care.

With regard to hepatitis C, there have been for quite some time now recommendations to screen all individuals for hepatitis C who are age 18 and older as well as pregnant women, and this is universal screening as opposed to risk-based screening, which really has not been a very effective policy in the United States to finding all these individuals who are undiagnosed with chronic viral hepatitis. So the recent CDC guidance is a welcome addition and is now very much in concert and harmonizes with the current hepatitis C testing recommendations.

**Dr. Turck:**

And once we screen patients how can we set them up with the most appropriate line of care?

**Dr. Kwo:**

So historically, viral hepatitis – and we'll start with hepatitis C – has been a disease where they came to a specialist, such as myself, our liver doctors, infectious disease doctors, and we would take several weeks to months to evaluate these people and treat. We now have such highly effective therapies, and hepatitis C can be cured, and it's one of the few diseases with direct acting antiviral agents that we actually cure and we have the opportunity to eliminate without actually having an effective vaccine yet, and so we want to be able to diagnose individuals and decentralize care. So where do these people wind up? These people come to addiction centers, they'll come to their family physicians, and they'll come to a variety of community health centers. We want the ability to scale up so we can make diagnoses of hepatitis C on when they visit and then write prescriptions, which are typically 8 to 12 week durations of therapy, and these individuals with this model should be able to be successfully treated and cured for hepatitis C.

For hepatitis B, it's a bit more complicated because the treatment of the virus is more complicated. We don't have a curative treatment yet, but we have a suppressive therapy that works very, very well. Here we have to also make testing widely available, but we are also going to have to educate our primary care providers, and there are a variety of these care models around. There's one called the ECHO model, which is extended community health outreach programs where you can train various primary care providers to take care of individuals with viral hepatitis, and we're going to need to simplify our treatment algorithms for hepatitis B as well until we can get curative therapies for hepatitis B, but it's important now to identify these individuals and then successfully link them to care while educating a large number of healthcare workers to be able to take care of and manage the viral hepatitis. This will all have to be done in the context of linking these individuals to harm reduction measures as well.

**Dr. Turck:**

Now we've certainly covered a lot of ground today, so before we close, Dr. Kwo, what are some key lessons you'd like learners to take away from our discussion?

**Dr. Kwo:**

Sure. Number one – you can cure hepatitis C, and that's very important. We don't have many diseases that we cure – we don't cure

diabetes, we don't cure hypertension – you can cure hepatitis C, and given that hepatitis C used to be the leading indication for liver transplant and still likely causes the most liver cancer in the United States, this is a remarkable achievement. So we want our primary care and all healthcare workers to know that they should be trying to diagnose these individuals and appropriately link them to care and that the care is straightforward.

With regard to hepatitis B, we can't cure hepatitis B, but we have excellent suppressive therapies, and again, our treatment approaches are being simplified now. There aren't enough specialists to take care of all the hepatitis B and C in the US, and we're going to therefore rely on our community healthcare workers and our primary care doctors. These are all the frontline individuals who will play an important role in helping us to reduce and eliminate the risks associated with chronic viral hepatitis, and again, it's encouraging to see that there are national and worldwide initiatives also to eliminate these threats and improve the liver-related health and overall health of all of our citizens worldwide.

**Dr. Turck:**

Those are some compelling considerations to take with us, and as that brings us to the end of today's program, I want to thank my guest, Dr. Paul Kwo, for joining me to discuss best practices for the management of patients with hepatitis infections. Dr. Kwo, it was great having you on the program.

**Dr. Kwo:**

Thanks so much for having me.

**Announcer:**

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