Chronic Viral hepatitis and Primary Care

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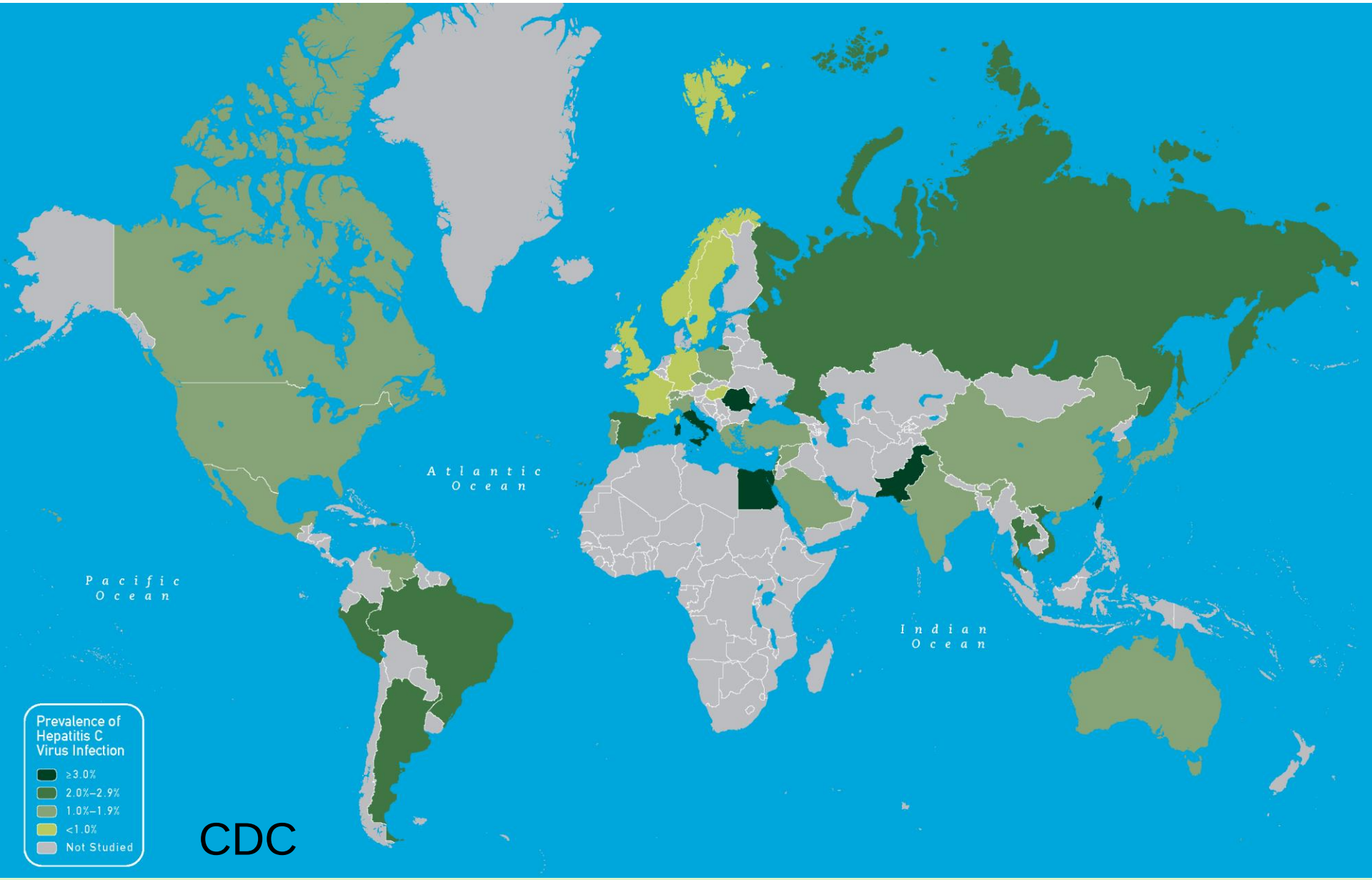
Hepatitis C

- ssRNA virus, transmitted by blood, sexual contact
- 6 main genotypes (G1 commonest in UK)
- Largest UK epidemics in ex/current IVDU + MSM

- 15% clear acute infection spontaneously
- 30% of those with chronic infection develop cirrhosis over a life-time, assuming infection in 20s
- Risk of HCC is around 2% per year with cirrhosis

Worldwide distribution – c150 million infections



CDC

HCV disease staging

- Surrogate Markers for fibrosis/ hepatic dysfunction portal hypertension/ splenomegaly:

- Albumin
- PT
- bilirubin
- platelet count
- Biochemical panels available commercially
- AFP for HCC

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HCV disease staging - imaging

- Ultrasound/MRI – HCC, NASH, and portal hypertension
- Hepatic stiffness (Fibroscan) – good at extremes eg mild or advanced fibrosis
- Endoscopy – assessing and treating varices in cirrhosis

Treatment – cure is possible..

- Used to be genotype specific

Eg 24 weeks of peg IFN and RBV for geno 2/3 and 48 weeks of peg IFN + RBV +PI in geno 1.

Now a whole range of direct acting agents (DAA)

Including NS5A and NS5B polymerase inhibitors, as well as second generation PIs.

- We are entering the era of interferon free pan genotypic treatment using a single pill for 12 wks!

Management and indications for Rx

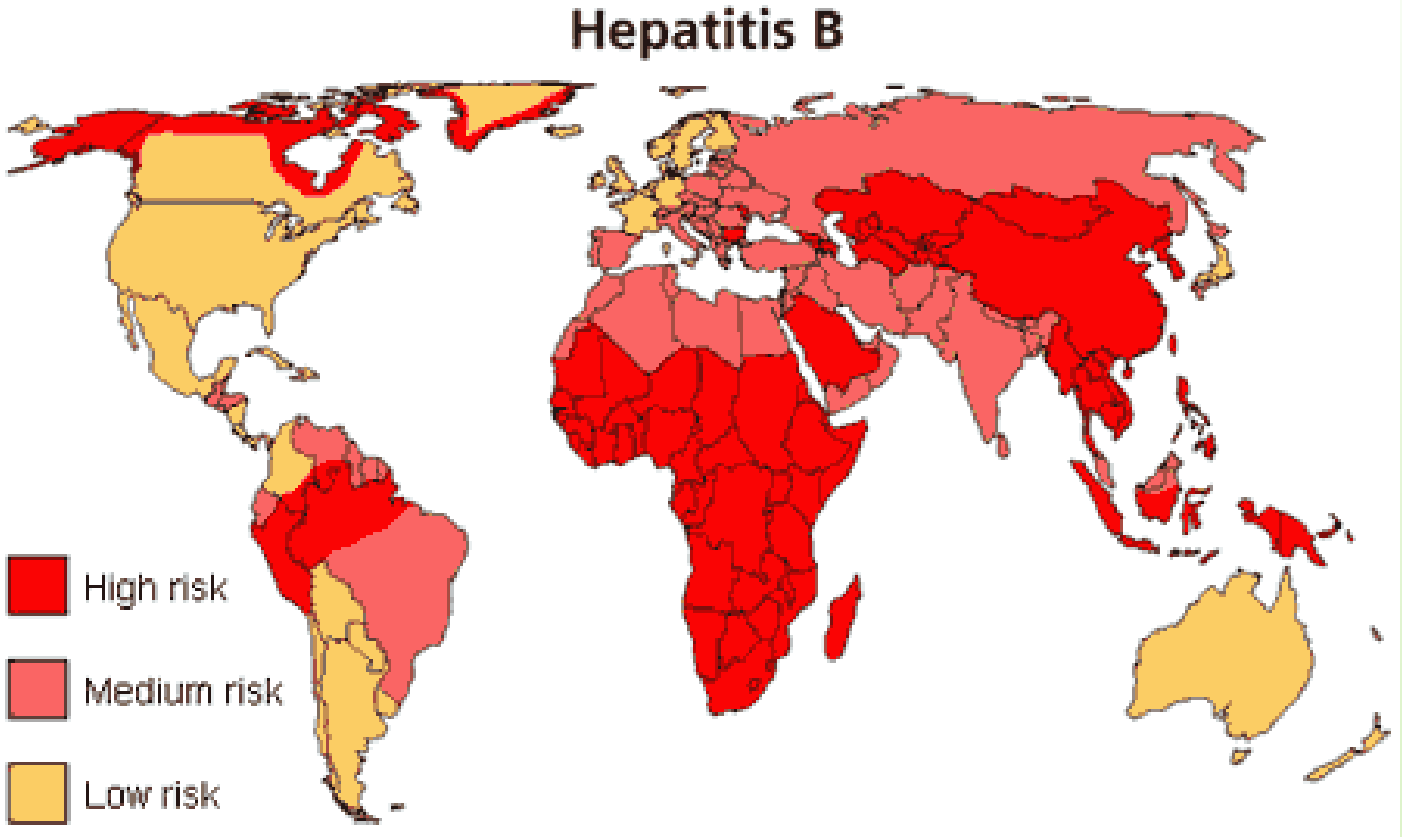
- Severity of liver fibrosis usually main indication for treatment
- Also complications such as cryoglobulinemia

We should be seeing and assessing all new HCV dx

- Usually 6-12 monthly follow up.
- Cirrhosis – 3-6 monthly follow up for HCC
- Usually not referred back to primary care

Chronic Hepatitis B

- >250 million infections worldwide, 780,000 deaths/yr



WHO

Management of chronic HBV

- Given the high prevalence in migrant communities in London (2% in South Asians) and the indolent course of infection in the majority, management is particularly challenging in an era of austerity.

Workup

- Patient history, including country of birth, age at move to UK, data on HBV in parents / siblings
- Hx of other infection routes: tatoos, CSW, transfusions.
- Co-morbidities, including HCV, HIV.
- Medication, alcohol, potential aflatoxin exposure
- Family history of liver diseases

Clinical Examination

- Peripheral stigmata of CLD: spider naevi >5; clubbing, palmar erythema, oedema

- Hepato/ splenomegaly
- Ascites
- Liver flap, CNS

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- **Hepatitis Delta testing**

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Indications for treatment

- Data from Asia demonstrate significant increase in risk of HCC above 2000 IU/ml.
- Case control data from West Africa suggest that HCC risk is increased at VL between 200 and 10,000 IU/mL.
- Guidelines in UK indicate that treatment should be offered if VL consistently >2000 IU/mL

Treatment I

- NICE recommend use of pegylated IFN alpha for 48 weeks
- Only 30% chance of sustained response (sAg)
- Balance against side effects: mylagia, depression, thyroid, bone marrow suppression, hair loss, vasculitis

Treatment II – POLYMERASE INHIBITORS

- Tenofovir most widely used agent as monotherapy
- >95% suppression
- Resistance at rebound uncommon
- Sero conversion at 5 years is less than 5%
- Long term therapy therefore inevitable with current approach.
- Other agents: entecavir, telbivudine, lamivudine