DECISION MAKING IN HEPATITIS C

HCV

1 When To Test

Clinical Indicators

- Abnormal liver function tests (LFTs) (males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L)
- Jaundice

Presence of Risk Factors

- Injecting drug use (current/ever)
- Sharing of snorting equipment
- Born in high prevalence region^
- Blood transfusion before September 1991 or a blood product (such as clotting factor) before 1986 in the UK
- Recipient of organ or tissue transplants before 1992 in the UK
- Unsterile tattooing/body piercing
- Unsterile medical/dental procedures/blood transfusions in high prevalence countries
- Time in prison
- Needlestick injury
- Mother to child transmission
- Sexual transmission in men who have sex with men (MSM)
- Sexual transmission in those who are HIV positive

^Africa, the Middle East (in particular Egypt), the Mediterranean, Eastern Europe, and South Asia

Other

- Initiating PrEP
- When someone requests a test

When gaining informed consent before testing, discuss:

- Reason for test
- Availability of curative treatment

2 Test/s, Results and Actions

Order HCV Antibody (Ab)*

HCV Ab negative

HCV Ab positive

HCV RNA (qualitative) **+ LFTs**

HCV RNA negative

HCV RNA positive

Does NOT have HCV

NO action
However, if possible recent infection re-test (HCV Ab) or if ongoing risk factors repeat screening (HCV Ab) annually

Has CLEARED HCV

RE-TEST if:
Ongoing risk factors
(repeat RNA test annually)

Has CHRONIC HCV
(chronic = > 6 months)

Further ASSESSMENT and TREATMENT
(see next page)

When conveying a negative result, discuss:

- Modes of transmission and risk reduction

When conveying a positive result, discuss:

- Modes of transmission and risk reduction
- Availability of curative treatment
- Lifestyle factors e.g. alcohol minimisation, diet
- Availability of peer support services, information and support services

***If high level suspicion also consider requesting reflexive HCV RNA + LFTs**

INHSU

This resource was created by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine and has been adapted for the UK by the International Network on Health and Hepatitis in Substance Users in collaboration with local partners

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3 Pre-Treatment Assessment

Baseline screening after positive HCV PCR

- ☐ Full Blood Count
- ☐ Urea, electrolytes, creatinine
- ☐ LFTs (including AST) and INR

Assess liver fibrosis: cirrhotic status

- ☐ Signs of chronic liver disease (spider naevi, palmar erythema, jaundice, encephalopathy, hepatomegaly, splenomegaly, ascites, peripheral oedema)
- ☐ Non-invasive assessment of fibrosis:
  - Serum biomarkers such as APRI (<1.0 means cirrhosis unlikely). Calculator available www.hepatitisc.uw.edu/page/clinical-calculators/apri
  - Elastography assessment e.g. Fibroscan® (>12.5 kPa consistent with cirrhosis)

Check for other causes of liver disease

- ☐ Check for viral coinfection:
  - HIV Ab
  - Hepatitis A – check hep A IgG; vaccinate if negative
  - Hepatitis B – check HBsAg, anti-HBc and anti-HBs; vaccinate if all negative
- ☐ Heavy alcohol intake
- ☐ Fatty liver disease - check weight, BMI

Check for other major co-morbidities

- ☐ Renal impairment (eGFR < 50)

Review previous HCV treatment

- Choice/length of treatment may be influenced by prior HCV treatment experience/response

Consider pregnancy and contraception

- HCV treatment not recommended for use in pregnant or lactating women

4 Treatment

Is your patient likely to have cirrhosis?
(APRI ≥ 1.0 or Fibroscan > 12.5 kPa

☐ Yes

Discuss with or refer to a specialist#

☐ No

Has your patient received previous treatment for HCV?

☐ Yes

Discuss with or refer to a specialist#

☐ No

- Click HERE to view treatment recommendations for **England**
- Click HERE to view treatment recommendations for **Scotland**
- Click HERE to view treatment recommendations for **Wales**
- Click HERE to view treatment recommendations for **Northern Ireland** (NHS Scotland)

☐ Check for drug-drug interactions at www.hep-druginteractions.org.

Additional information can be found at:

- Hepatitis C in the UK 2020
- Northern Ireland Hepatitis C Elimination Plan: phase 1 2021-2025

#All patients with cirrhosis or prior HCV treatment experience should be reviewed by someone experienced in hepatitis C treatment. If cirrhosis is suspected (APRI ≥ 1.0 or elastography > 12.5 kPa), further evaluation is required before commencing treatment.

5 Monitoring

Monitoring while on treatment

- Generally not required but approach should be individualised
- Side effects of HCV treatment are generally minimal

12 weeks post treatment

- ☐ HCV RNA to confirm cure (sustained virological response SVR12 = cure)
- ☐ LFTs

6 Follow Up

If your patient has no cirrhosis and normal LFT results (males, ALT< 30 U/L; females, ALT < 19 U/L) ALT = alanine aminotransferase

No clinical follow-up for HCV required

If your patient has ongoing risk factors

Annual HCV RNA test. If re-infected offer re-treatment and harm reduction strategies

If your patient has abnormal LFT results

(males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L)Evaluate for other causes of liver disease and refer to specialist for review

If your patient has cirrhosis

Refer to specialist. Patients with cirrhosis require long-term monitoring:

- 6-monthly abdominal ultrasound (hepatocellular carcinoma screening)
- Consideration of screening for oesophageal varices
- Osteoporosis: 2-yearly DEXA scans and monitor serum vitamin D

CONSULT WITH A SPECIALIST IF:

Pre-treatment

- Prior treatment failure of HCV treatment
- Cirrhosis is present or likely – APRI ≥1 and elastography score not available; elastography >12.5kPa
- Coinfected with HIV or HBV
- Renal impairment (eGFR < 50)
- Complex drug interactions
- Complex co-morbidities
- Not comfortable prescribing HCV treatment

During treatment

- Major medication side effects

Post treatment

- RNA positive 12 weeks post treatment
- Abnormal LFTs at SVR12

Disclaimer: Guidance provided on this resource is based on guidelines and best-practices at the time of publication. This quick-reference guide is not intended to be a comprehensive list of all available options.

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