Chronic Hepatitis C: The Drug and Alcohol Perspective

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The Global Challenge
Chronic hepatitis C virus (HCV) infection is a major global health problem. It is estimated that 71 million people were living with HCV in 2015, and that 1.75 million adults were newly infected during that year, according to the World Health Organization.

The global target for 2030 is to test 90% of those infected and to treat 90% of those who test positive. It is expected that this measure will reduce HCV-related mortality by 65%.

In the United States, the Centers for Disease Control and Prevention encouraged the screening of baby boomers a few years ago, as those born between 1945 and 1965 showed the highest prevalence of HCV infection.

Screening strategies will have to be expanded to meet the 90% target, especially if they are to capture new infections in young adults, a group that is seeing an increase in infections in the U.S. because of the opioid epidemic.

In fact, HCV infection is associated with injection drug use in 2/3 of the cases in developed countries and is also associated with unsafe therapeutic injections in the developing world. Globally, almost 40% of HCV burden of disease is attributable to injection drug use.

The Changing Landscape of Treatment
The advent of interferon-free therapies, with so-called direct-acting antivirals, has changed the landscape of HCV antiviral therapy. Depending on the medications used, the length of treatment, and the presence of individual factors like liver cirrhosis or HCV genotype, sustained viral response (SVR), an equivalent to HCV infection cure, is achieved in more than 90% of the patients treated. Interestingly, the rate of SVR is even higher in real world studies.

Despite this, active drug or alcohol use is one of the main reasons why HCV antiviral therapy is not prescribed, mainly because of prescriber’s concern around potential poor adherence to treatment or of reinfection after or during treatment.

New research shows that active alcohol or drug users can be safely treated with interferon-free
regimens with a high rate of SVR. Promising results with direct observed therapy in methadone clinics and in other primary care settings show that providing treatment for patients who use alcohol or other drugs is feasible.

Barriers and Future Strategies

However, some systemic changes will have to occur in order to address the various barriers to antiviral treatments. More inclusive strategies are needed to increase the impact of HCV antiviral therapy at a population level. Accordingly, HCV antiviral therapy must be expanded beyond specialty care and primary care providers should be enabled to treat their HCV-infected patients.

In addition, outreach strategies will be needed to capture difficult to reach HCV-infected patients and engage them in care. In this regard, strategies like the use of peers among people who inject drugs (PWID) or systematically screening all patients that attend a given healthcare center should be explored and expanded to other settings if found to be effective.

Medication cost will also have to be addressed as treating all HCV-infected patients will have a substantial short-term burden in healthcare budgets, even in wealthier countries. Nevertheless, health economic models suggest that the prevention benefits of HCV antiviral therapy is likely to be cost-effective.

Scaling-up HCV treatment, as well as other harm-reduction measures for PWID, like needle-exchange programs and methadone and buprenorphine treatment for opiate use disorders, will be needed to tackle the global health problem that HCV infection represents.

Dr. Fuster M.D, Ph.D is an internist within the Internal Medicine Service-Addiction Unit at Hospital Universitari Germans Trias i Pujol in Badalona, Spain. He is also an Associate Professor within the Medicine Department at Universitat Autonoma de Barcelona. His research interests are the medical consequences of alcohol and drug use. Dr. Fuster has authored more than 40 peer-reviewed manuscripts and over 90 conference communications. He is currently an associate editor at Addiction Science & Clinical Practice. This post originally appeared on the BioMed Central blog network and is reprinted with permission.