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 transfusions and blood products before 1990 in Australia
- 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

Has CLEARED HCV

Has CHRONIC HCV
(chronic = > 6 months)

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

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

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
- Life style factors e.g. alcohol minimisation, diet
- Availability of peer support services, information and support services
- Refer to Hepatitis Australia National Infoline 1800 437 222

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

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HCV

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 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

For more information www.hepcguidelines.org.au.
To discuss cases with your peers visit the ASHM Hepatitis C Community of Practice at www.ashm.org.au/hepc-forum/

~SOF/VEL = Sofosbuvir/Velpatasvir ; GLE/PIB = Glecaprevir/Pibrentasvir

 ISBN: 978-1-921850-47-9

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

Treatment	Dosage	Duration if no cirrhosis present	Duration if compensated cirrhosis (Child Pugh A) present
SOF/VEL~ (Epclusa®)	400/100mg Once-daily (1 pill)	12 weeks	12 weeks
GLE/PIB~ (Maviret®)	100/40mg per pill Once-daily (3 pills)	8 weeks	8 weeks†

- ☐ Check for drug-drug interactions at hep-druginteractions.org
- ☐ Call the PBS Authority Script Line (1800 020 613) for approval

Consult with your local specialist or complete the online remote consultation form at reach-C.ashm.org.au (turn-around time <24 hours).

 # 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.

† A treatment duration of 12 weeks may be considered for patients with compensated cirrhosis at the discretion of the prescriber.

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 events

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. Refer to the General Statement for Drugs for the Treatment of Hepatitis C for all current PBS-listed regimens.