More Infectious Disease Docs Treat Hep C

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We may soon see an end to obstacles in the care of people living with chronic hepatitis C virus (HCV)—but only if infectious disease (ID) doctors work with and learn from hepatologists, according to an opinion piece authored by Barbara McGovern, MD, of Tufts University School of Medicine and published online ahead of print by Clinical Infectious Diseases.

ID specialists have historically been reluctant to treat hepatitis C, even among their own patients living with HIV, because of the complexities of prognostic testing and combination treatment, low cure rates among people with genotype 1 HCV and the need for expert management of side effects.

HCV coinfection is more amenable to treatment now than in the past—including for those coinfected with both HIV and HCV—with the current generation of direct antiviral agents providing a 75 to 85 percent cure rate.

Further improvements—such as all-oral regimens that don't involve interferon—are expected within the next few years and will likely benefit both HCV-monoinfected and HIV/HCV-coinfected patients. This would be a great boon for all people living with HCV, for whom treatment can lead to remission of liver disease and reduced risk of liver cancer and cirrhosis.

With an estimated 170 million HCV cases worldwide—including 5 million in the United States, where hepatitis C death rates now exceed those from HIV—hepatologists, the usual go-to medical experts for hepatitis C care and management, are overwhelmed by the number of patients seeking their services. Their efforts will be stretched even thinner if the Centers for Disease Control and Prevention (CDC) implements planned screening guidelines that recommend testing everyone born between 1945 and 1965—an age range with an especially high HCV prevalence.

Bringing more people into care for hepatitis C, McGovern argues, will require expanding the ranks of ID specialists capable of dealing with the virus and its complications.

One reason HCV care has required highly specialized attention from hepatologists was the need for a liver biopsy to measure the progress of the disease. This may no longer be necessary, thanks to noninvasive testing via such methods as blood tests and elastography (measurement of tissue stiffness via ultrasound or magnetic resonance), which can be performed by ID specialists.

Another main reason why hepatologists have been needed for HCV therapy is the risk of decompensated cirrhosis—when a cirrhotic liver begins to lose its ability to function—for patients who don't receive antiviral therapy or whose therapy fails. Managing the complications of

decompensated cirrhosis requires a hepatologist’s specialized training. However, early HCV treatment greatly decreases the risks of cirrhosis.

Lastly, modern combo therapies for HCV require extensive knowledge of the relevant antiviral drugs and their interactions.

McGovern recommends sidestepping this dearth of hepatologists by cross-training ID specialists in the intricacies of HCV infection. Her recommendations include establishing “centers of excellence” and instituting joint fellowships wherein HCV experts can pass their knowledge along to ID physicians; presenting conferences and workshops devoted to HCV evaluation and management; collecting data from the membership of the Infectious Diseases Society of America (IDSA) on obstacles to hepatitis C patient care; and offering real-time updates to HCV treatment guidelines.

“Although HCV does not command the same media attention as for some emerging infectious diseases,” McGovern wrote, “advancing liver disease will be exacting a tremendous toll in morbidity and mortality in the decades to come if wider access to treatment is not realized in the near future. In fact, in 2007, deaths from HCV infection exceeded deaths from HIV in the United States. Millions of HCV?infected patients will be depending on an expeditious response from the ID community, as we have done for many other infections in the past.”

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