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Medical Writers' Circle

a series of articles written by medical professionals about the management and treatment of Hepatitis C

Managing the HCV Veteran

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Hepatitis C virus (HCV) is a leading cause of chronic liver disease in the United States, and previous studies indicate that as many as 1.8% of the population may have been exposed to the HCV virus. Many people infected with the hepatitis C virus have immune systems that are able to fight off and eradicate the infection. In others, the infection may persist, but in a relatively "dormant" state, resulting in very little damage to the liver over many years. In a smaller group of patients, the virus can slowly cause the accumulation of fibrosis (scar tissue) in the liver, which can result in cirrhosis, liver failure, or liver cancer [1-5]. The projected mortality in the United States due to HCV-related chronic liver disease and liver cancer is expected to total over 200,000 individuals between 2010-2019 [6]. Current Centers for Disease Control (CDC) estimates are that medical and work-loss costs of HCV-related acute and chronic liver disease are over $600 million annually in the United States. This is of considerable concern for physicians at Veterans Affairs (VA) Medical Centers, because point-prevalence surveys at several urban VA Medical Centers indicate that 12-35% of inpatients and outpatients are positive for antibodies to HCV [7-11]. The high prevalence of HCV among veterans who are patients at VA Medical Centers can be anticipated to have a significant impact on current and future health care resources.

The treatment of HCV disease is rapidly evolving with impressive improvement over the last few years in achieving eradication of the HCV virus. Treatment with the combination of interferon alfa (IFN) and ribavirin provides a 2 to 5 fold improvement in virologic response rates compared to monotherapy with IFN preparations, with sustained virologic response rates of 38-43% [12, 13]. Reports of treatment results with the use of pegylated interferon alfa-2b or pegylated interferon alfa-2a, in combination with ribavirin, indicate an overall sustained virologic response rate of 54% and 56%, respectively [14, 15]. Recent data indicate that if patients receive optimal weight-based dosing and are compliant with the medications, the overall sustained virologic response rate is 61%[14]. Furthermore, recent studies of large numbers of patients from controlled trials with paired liver biopsies have shown that IFN or IFN/ribavirin treatment resulted in reduced fibrosis progression, and in some case fibrosis regression, compared with no treatment [16-18]. The effect of IFN therapy on progression to hepatocellular cancer is not conclusively defined at this time, but several studies suggest that IFN may reduce cancer risk also [19]. Economic studies have demonstrated that treatment of mild chronic HCV with IFN alone [20, 21] or IFN and ribavirin [22] prolongs average life expectancy at a reasonable marginal cost per year of life gained. The accumulated data at the present time indicate that a window of opportunity exists for aggressive treatment of patients with chronic HCV who are at risk for the development of cirrhosis, in order to reduce the anticipated future health care burden of end-stage liver disease.

Despite the availability of anti-viral therapies and treatment guidelines for HCV, few data are available concerning anti-viral treatment rates in community-based studies of patients with HCV. Some population-based series indicate that only a small minority of patients with hepatitis C have received antiviral therapy [23]. The reasons for this are complex, and

involve factors related to patients, practitioners, and institutions. Preliminary data from a multicenter survey study of 5035 HCV patients at VA Medical Centers from 9/99 to 12/00 reported that 3169 (63%) patients were considered to be ineligible for treatment with interferon alfa and ribavirin [24]. Of the patients considered ineligible, psychiatric conditions and active substance abuse were considered reasons for refusal of therapy in 16.3 and 17.5%, respectively. Medical contraindications for receiving treatment were found in 61% of these patients, and included thrombocytopenia, neutropenia, decompensated liver disease, renal dysfunction, and other medical conditions. Researchers at the St. Louis VA Medical Center recently reported that of the 557 patients with presumed HCV infection who were given appointments to the hepatitis C clinic, only 242, or 43%, actually presented for at least one appointment. Of the 242 patients who were seen in their clinic, 165 or 68% were deemed unsuitable for or refused HCV antiviral therapy. Reasons for exclusion included the presence of psychiatric disease (21%), undecided (17%), active alcohol abuse (14%), refused therapy (10%), multiple reasons (10%), and miscellaneous other reasons in 26%. We have recently shown that psychiatric diagnoses are common in veterans with hepatitis C who are attending a chronic hepatitis clinic. Of 33 consecutive patients who received treatment in this clinic, 18 (54%) patients had established psychiatric diagnoses, the most common being depression or post-traumatic stress disorder [25]. We found that veterans with HCV and established psychiatric diagnoses were more likely to have an adverse event during interferon monotherapy that would lead to interruption or discontinuation of therapy compared with veterans without psychiatric diagnoses. This was a retrospective study of patients early in our experience with IFN treatment. We are unaware of data suggesting that such patients are at higher risk for complications or treatment failure when provided with optimal psychiatric and substance abuse treatment. In a more recent study, we have found that patients with psychiatric disorders, including depression, are able to successfully complete treatment when monitored with a protocol using objective depression scales and treated appropriately with anti-depressants [26]. These patients were found to have end-of-treatment response rates similar to those of patients without psychiatric disorders. These studies indicate that many veterans with hepatitis C at VA Medical Centers are not availing themselves of clinical services, and that many patients have concurrent psychiatric, substance use, and medical problems that may serve as barriers to receiving antiviral therapy. These factors represent the challenge of translating research findings, treatment guidelines, and theoretical best practices into actual medical practice with patients.

Recently there has been a growing awareness that linkage of psychiatric and medical care can result in numerous benefits for patients, medical care providers, and psychiatric care providers [27-30]. Willenbring and Olson studied medically ill alcoholics and found that an integrated approach combining comprehensive medical care and interventions aimed at alcoholism resulted in increased engagement in treatment and abstinence from alcohol [30]. Druss, et al., have shown that veterans with serious psychiatric illness who were seen in an integrated general medical and mental health care clinic demonstrated significantly more primary care visits, greater improvement in a survey of physical symptoms, and no increase in costs compared to a usual care group [31]. These data form the basis for our belief that care for veterans with HCV is best given in the context of a multidisciplinary, combined medical, psychiatric, and substance abuse clinic.

The Minneapolis Hepatitis C Resource Center was recently designated and funded by the Public Health Strategic Health Care Group, Office of Public Health and Environmental Hazards, Department of Veterans Affairs. This is one of four designated VA Hepatitis C Resource Centers in the nation, whose overall goal is to optimize the numbers of veterans with HCV who are able to receive comprehensive, safe and effective care at VA Medical Centers. The Minneapolis Hepatitis C Resource Center will help develop clinical models that would include the linkage of medical care and psychiatric services, both to expand the numbers of veterans who might be considered eligible for care and to optimize the success and safety of therapy. The Center will help to create "tools" and manuals to help train practitioners at VA Medical Centers to implement best practices for hepatitis C. These efforts will help to "translate" the scientific breakthroughs in antiviral treatment to practical and effective methods for caring for patients in our clinics.

The high prevalence of HCV among veterans who are patients at VA Medical Centers can be anticipated to have a significant impact on current and future health care resources.

Visit the Department of Veteran's Affairs Hepatitis C Resource Center web site at http://www.va.gov/hepatitisC/

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is a program of the Hepatitis C Support Project.

The Mission of the Hepatitis C Support Project is to offer support to those who are affected by the hepatitis C Virus (HCV) and HIV/HCV coinfection.

Support is provided broadly, through information and education, as well as access to support groups. The (Project) seeks to serve the HCV community as well as the general public.

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