

Medical Writers' Circle

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

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Hepatitis C in Drug Users: What to Do?

We seem to have become accustomed to the term “special populations” as it is applied, incomprehensively, to the majority of patients who have hepatitis C: those with addictions, mental illness, and the like. Singular? Unique? Maybe. But what we really mean is, the patients with hepatitis C that present unusual challenges, the ones that we rarely study because of the difficulties involved. Apparently the silly euphemism is a little easier for most people to swallow.

Take, for example, drug users. Few patients elicit as much consternation as the patient who continues to use drugs. In addition to being a potential source of ongoing HCV transmission, these patients may have poor adherence to health care regimens, high rates of comorbid psychiatric illness, psychosocial instability, and poor health literacy. Plenty of doctors don't even want to go near them. But here is the conclusion of the section

entitled “Active Injection Drug Users” from the 2002 NIH Consensus Statement on Hepatitis C: *“Thus, it is recommended that treatment of active injection drug use be considered on a case-by-case basis, and that active injection drug use in and of itself not be used to exclude such patients from antiviral therapy.”*¹

What? Treat active injection drug users for hepatitis C? Wasn't that recommendation made by a panel of experts? What were they smoking?

Ok, so no one really says that. But honestly, the prevailing opinions and practice in the world of hepatology are a universe away from the generous recommendations of the 2002 Consensus Statement. The majority of drug users struggle to just get HCV screening tests and hepatitis A and B vaccinations, and referrals for virologic testing, liver biopsy, and hepatitis C treatment are often remote if not nonexistent options.

This dichotomy is partly based on evidence and

partly based on stigma and prejudice. The key to successfully addressing HCV in drug users is to become familiar with the HCV treatment evidence as it exists, and to understand some of the simple and effective tools that addiction specialists use in their management of these often-challenging patients.

Treating HCV in Drug Users: The Evidence to Date

Although there is a robust body of data on hepatitis C treatment outcomes, it is important to recognize that the large scale registration trials routinely excluded patients with addiction problems. Active drug users were uniformly excluded, the majority of studies excluded patients with psychiatric illness, and many even excluded patients maintained on methadone. In the light of the high prevalence of intervening drug use and comorbid psychiatric illness, this leaves us with a limited understanding of the expectations of hepatitis C

treatment outcomes in real world patients with addictive disorders.

However, there are a number of smaller studies demonstrating that addicted patients can successfully undergo treatment for HCV in a setting that can address their special needs. In the first reported

between the two groups, and neither group had serious psychiatric events.

Similarly, Sylvestre, et al., studied HCV treatment in 76 methadone maintained patients and showed that there was no significant difference in outcomes in patients with <6 months of abstinence

Addiction Is a Medical Illness

The truth is, just because it's possible doesn't mean it's easy. Addiction is completely different from using, and even abusing, drugs. You can't "Just Say No." It is a chronic, incurable medical condition that shares features

the frustration of the inveterate drug or alcohol user who repeatedly fails to take our advice despite obvious negative consequences. This kind of resistance toward behavior change is common. The Stages of Change model, which grew out of work in the area of smoking cessation and is now a widely applied approach to substance use, can be a useful construct for understanding a patient's continuing use of drugs and can help tailor an intervention that may lead to positive behavior change.

This five-stage model recognizes that for every behavior we wish to eliminate, be it ongoing drug use, excessive caloric intake, dietary indiscretion, or poor medication adherence, our patients fit along a continuum of motivation with respect to accepting our advice. The key to success is to recognize the patient's place along the continuum, and then to select an intervention that will help move him or her through the motivational steps and closer to our goal. Patients are in the **Precontemplation** stage when they are unaware or underaware that their substance use behaviors are a problem. Without an understanding of the need for sobriety, a message to stop using drugs at this stage is destined for failure. These patients respond best to simple information that can help them consider making a behavior change, such as that alcohol use makes hepatitis C

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study of its kind, Backmund, et al, treated HCV in 50 heroin injectors as they enrolled in a methadone detoxification program in Germany.⁵ Using standard interferon monotherapy or interferon/ribavirin combination therapy, the SVR was 36% and was not significantly different for the patients who relapsed and returned to treatment (53%), who relapsed and did not return to treatment (24%), or who did not relapse (40%). Mauss, et al, prospectively treated HCV in 100 patients, 50 of whom were maintained on methadone and 50 of whom either had no history of addiction or had not been on methadone for at least 5 years.²³ Although the discontinuation rate due to noncompliance in the first 8 weeks was higher in the methadone group, there was no significant difference in sustained response rates

or intervening drug use; although outcomes were significantly lower in patients with preexisting psychiatric conditions, this was not related to adherence and may possibly have been related to interactions with psychiatric medications.⁷ Most recently, Robaey, et al., conducted a retrospective multicenter cohort analysis of 406 treatment-naïve HCV patients, of whom 24% were injection drug users.²⁴ About a quarter of the IDUs were maintained on methadone, and a similar proportion injected drugs while on antiviral therapy. Despite this, the injection drug users were found to have similar rates of compliance and treatment response as compared to other patients in the study. There appears to be a trend: so why the controversy?

with other chronic conditions like diabetes, hypertension, and asthma in which adjunctive interventions such as weight loss, dietary restraint, and smoking cessation do not eliminate the condition but help ameliorate its consequences. And just as you would not consider a doughnut-eating diabetic hopeless, understanding that drug relapse is a normal and treatable characteristic of addiction is an important aspect in maintaining a productive relationship with a patient who uses drugs.

And with hepatitis C treatment, it's all about productive relationships. Engagement is key. In addition to recognizing addiction as a chronic illness, a familiarity with the **Stages of Change** model of substance use behaviors can be helpful in approaching patients who continue to use drugs. We are all familiar with

more dangerous or that drug use may increase the risk of infections.

The second stage is **Contemplation**, in which patients may be aware that their behavior is a problem but are ambivalent about making changes. These patients vacillate between the difficulties created by the drug use and the challenges required to stay sober. This is a stage at which interventions can target some of these challenges, such as pharmacotherapy for depression, as a means of facilitating progress to the next stage. These patients are not yet mentally or physically prepared for abstinence and need further education and encouragement to achieve this goal. The next stage is **Preparation**. A decision has been made in favor of change, and goals are being set even though drug use continues. Typically, this is a stage at which the quantity or frequency of drug use is reduced. During the preparation stage, information about treatment options will be more welcome and a quit date can be set.

It is not until these stages have been traversed that the patient will finally enter the **Action** stage and attempt to stop using drugs. This is a stage at which the clinician may need to treat physiological withdrawal and help manage the consequences of sobriety, such as the emergence of an unrecognized anxiety or panic disorder. During this stage an hon-

est and non-judgmental partnership with the patient is critical; if he or she feels uncomfortable discussing problematic behaviors with the healthcare provider, the sobriety will be brief and unsuccessful.

Finally, a patient who successfully negotiates the action stage enters the consolidative **Maintenance** stage, in which new coping patterns for emotions and relationships will be developed and the foundations are laid for more lengthy sobriety. Relapse at this stage is common and often a product of success; the patient feels dramatically better after a sustained period of abstinence and begins to believe he or she can return to occasional or controlled use and maintain other gains. Although the patient is often remorseful and shamed, relapse is normal and offers an opportunity to teach the patient more about addiction and recovery.

The power of this model lies in its ability to guide the selection of interventions and to provide a framework for accepting and assisting problematic patients regardless of their interest in or motivation toward change. For instance, a belief that the patient is in denial often provokes an adversarial relationship, whereas recognition of that patient in the Precontemplation stage can suggest a more measured approach to helping the patient to connect alcohol and other drug use

to specific negative consequences in his or her own life. In this conceptual framework, it is mismatch between the provider's perception and the patient's stage of change that is usually responsible for lack of success. Application of the stages of change framework allows the pace of the intervention to match that of the patient's ability to carry it out.

A final recommendation about treating the patient who is using drugs would be to understand the neurochemical underpinnings of addiction. The long-term abuse of psychoactive substances leads to well-defined neurochemical changes that are slow to resolve and in some cases are irreversible. Because of this, short-term detoxification strategies, whether in- or outpatient and managed with or without medication support, will usually be unsuccessful. Avoiding unrealistic expectations is important, as is guiding patients toward more successful but perhaps more burdensome treatment options like methadone maintenance therapy or residential treatment.

A Strategy for Engagement

Let's face it. Understanding that active drug users can be successfully treated for hepatitis C and recognizing addiction's neurochemical underpinnings and successful approaches aren't enough

to ensure successful treatment outcomes in drug users with hepatitis C. But they are usually enough to get the process going, because engagement is key.

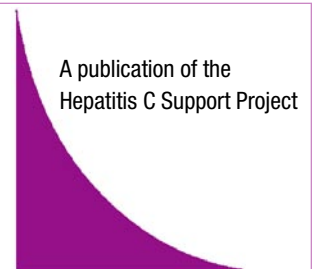
Recognizing that drug use in and of itself isn't a particular barrier to successful HCV treatment outcomes, we can express concern about its potential impact on adherence. And a good measure of the ability to adhere to HCV treatment is pre-treatment appointment attendance. Fortunately, hepatitis C usually isn't a medical emergency, and some of these visits can include referrals to psychiatrists and addiction specialists. Because of the immensely challenging nature of HCV treatment, it is also perfectly reasonable to require that active or newly abstinent users attend weekly NA or AA meetings and document attendance. Just make sure it's a therapeutic and not a punitive recommendation. When faced with a potentially life-threatening illness, patients usually do their level best to adhere to our medical recommendations, but many will bristle even at the suggestion of punitive authoritarianism.

Lastly, if you need help, ask for it. Addiction is widespread. Our Surgeon General called it our nation's number one medical condition. Although it is often not readily apparent, most communities have a wealth of experience in managing and treating ad-

dictive disorders and they will be surprised and delighted that someone with HCV experience is interested.

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Hepatitis C Support Project

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The Mission of the Hepatitis C Support Project is to offer support to those who are affected by the hepatitis C Virus (HCV), hepatitis B Virus (HBV) and HCV coinfections.

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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