

New HCV Treatment Guidelines from the Veterans Administration

Treatment Recommendations for Patients with Chronic Hepatitis C 1.0

Summary of Current Recommendations for Treatment

A. Treatment Naive Patients

Interferon alfa 2b plus ribavirin

Interferon 3 MU tid and ribavirin (1,000 mg for <75 kg, 1,200 mg for > 75 kg in two divided doses daily) with a decision to continue or withdraw therapy based on virological response at 24 weeks and assessment of the clinical needs of the veteran.

Or

Peginterferon alfa 2b (12 kD) plus ribavirin

Peginterferon alfa 2b 1.5 µg/kg q week plus ribavirin 800mg qd with a decision to continue or withdraw therapy based on virological response at 24 weeks.

Decision to Treat with Standard Interferon versus Peginterferon

Peginterferon plus ribavirin offers the convenience of dosing once a week, yet peginterferon and ribavirin treatment offers only a slight increase in efficacy and more adverse events (injection site reactions and neutropenia) compared with standard interferon plus ribavirin. This is true for patients with a genotype 1 infection and a high viral load and for genotype non-1 infection. For patients with non-1 infection, there are more data guiding decisions regarding the duration of treatment with standard interferon plus ribavirin than with peginterferon plus ribavirin. Until additional data are available, both peginterferon and regular interferon in combination with ribavirin are appropriate for many patients and that treatment choice should be based on both efficacy data and an individualized assessment of the risks and benefits of each form of therapy in each patient.

Treatment Duration

Genotype 1 Infection

Patients receiving interferon plus ribavirin (whether standard interferon or peginterferon) should be treated for 24 weeks. In those who are HCV RNA negative after 24 weeks, treatment should be continued for a total of 48 weeks. In those with detectable HCV RNA after 24 weeks, treatment should be discontinued because a sustained viral clearance with an additional 24 weeks of therapy is rare. Exceptions to this algorithm include patients with advanced disease who could in theory benefit from viral suppressive therapy and patients with either a biochemical or a virological response after 24 weeks but not both. Continued treatment for up to 48 weeks may be beneficial in these latter two groups. Benefits of treatment beyond one year in preventing long-term complications of liver disease are under investigation. Long-term suppressive therapy cannot be recommended until such data are available.

Genotype Non-1 Infection

Patients receiving standard interferon plus ribavirin should be treated for 24 weeks. In those who are HCV RNA negative after 24 weeks and have favorable characteristics of response, treatment should be discontinued. In those with unfavorable characteristics, treatment should be continued for a total of 48 weeks. In those with detectable HCV RNA after 24 weeks, treatment should be discontinued for the same reasons and with the same provisos as described above for genotype 1 infection. The treatment duration is less clear for peginterferon plus ribavirin because no 24 week studies have been performed. Until such data are available, one must assume that 48 weeks of treatment is necessary in maintaining the virological response observed after 24 weeks.

Ribavirin Dose

In combination with standard interferon alfa 2b, the dose of ribavirin is either 1,000mg (<75kg) or 1,200mg (>75 kg). In combination with peginterferon alfa 2b (12 kD), the dose of ribavirin is 800mg. The use of higher doses of ribavirin is under evaluation with peginterferon alfa 2b. Ribavirin is not effective as a single agent.

Ribavirin Toxicity

For patients who develop hemolytic anemia, the ribavirin dose should either be reduced or discontinued. Erythropoietin therapy to counter the anemia is only necessary if the veteran develops moderate symptoms from the anemia, or if symptomatic anemia persists despite ribavirin dose reduction.

Peginterferon alfa 2b Monotherapy as Potential First Line Therapy

While there are no prospective comparisons of peginterferon alfa 2b (12 kD) monotherapy with interferon alfa 2b and ribavirin, sustained virological responses appear to be lower in the former than in the latter group. Thus, peginterferon alfa 2b monotherapy should not be administered as first line therapy in treatment naïve individuals unless the patient has contraindications to ribavirin.

B. Treatment Naïve Patients with Contraindications to Ribavirin

Peginterferon alfa 2b Monotherapy as First Line Therapy

Pegylated interferon (1.0 µg/kg) should be given every week for one year. A decision to continue or withdraw therapy after 24 weeks is based on the virological response, regardless of the infecting genotype.

Other Interferons as Monotherapy

Given the superiority of peginterferon alfa 2b (12 kD) over standard interferon, treatment with interferon alfa 2a, alfa 2b, or alfa con-1 is no longer indicated as first line therapy in any population.

C. Non-Responders to Interferon plus Ribavirin Combination Therapy

No Approved Treatments for Patients who have Failed Interferon and Ribavirin

There are no approved treatments for this population. However, pegylated alfa 2b (12 kD) interferon plus ribavirin can be considered, preferably as part of an experimental protocol.

Visit the Veterans Administration's web site for comprehensive information on hepatitis C.

<http://www.va.gov/hepatitisC/>