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Hepatocellular Carcinoma: Risk Factors and Prediction

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Liz Highleyman

Hepatocellular carcinoma (HCC), a type of liver cancer, is a possible long-term consequence of chronic hepatitis B or C. The November 2004 supplement of Gastroenterology was devoted to the current state of knowledge about this condition.

HCC typically develops during later stages of liver disease – usually after 2-4 decades – in people who have extensive liver damage. Researchers from the Liver Cancer Network reported at last fall’s American Association for the Study of Liver Diseases (AASLD) meeting that more than half of U.S. liver cancer cases are linked to hepatitis C. According to a review article by Hashem El-Serag in the *Gastroenterology* supplement, the age-adjusted incidence of HCC in the U.S. has doubled over the past two decades, as people infected years ago develop advanced disease. But effective treatment of chronic hepatitis C – as well as widespread hepatitis B vaccination – could help reverse this trend.

HCC is associated not only with chronic viral hepatitis, but also with other forms of liver disease, including alcoholic cirrhosis (scarring) and hemochromatosis (iron

overload disease). Experts believe long-term liver inflammation and regeneration of damaged liver cells can ultimately lead to the uncontrolled cell proliferation that characterizes cancer. In a study of Japanese blood donors by Hideo Tanaka and colleagues (reported in the December 20, 2004 issue of the *International Journal of Cancer*), HCC risk was linked to elevated ALT levels, a sign of liver inflammation. In people with chronic hepatitis C, HCC almost always develops only in people with cirrhosis. In people with chronic hepatitis B, the integration of HBV DNA into the genome of host liver cells may also promote abnormal cell replication, and a small number of patients develop liver cancer even without cirrhosis.

Only a small percentage of people with chronic hepatitis B or C go on to develop HCC (an estimated 5% of people with HCV-related cirrhosis). Unfortunately, it is difficult to predict who will fall within this group, although several factors are clearly associated with increased liver cancer risk.

It is well known that advancing age increases the chances of liver cancer, which occurs most often

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in people age 50 or older. The HCC rate is 2-4 times higher in men than in women. In Dr. Tanaka’s study, for example, the cumulative HCC incidence during more than eight years of follow-up in a cohort of 1,927 HCV positive subjects was 21.6% for men compared with 8.7% for women. African-Americans and Latinos appear more likely to develop liver cancer than whites, and the rate among Asians is particularly high due to the high prevalence of chronic hepatitis B in this population.

According to a review by Timothy Morgan and colleagues, long-term heavy alcohol use (more than 80 grams per day for 10 years) increases the risk of HCC by about 5-fold, although studies suggest that light-to-moderate drinking is not linked to a significant increase in liver cancer. Other liver toxins, including tobacco smoke and aflatoxins from moldy grains, may also increase HCC risk.

As discussed by Stephen Caldwell and colleagues, a growing body of research links HCC to insulin resistance, diabetes, and obesity. For example, in a study

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by Marie-Claude Rousseau and colleagues reported at the Third Annual Frontiers in Cancer Prevention Research Meeting last October, people with diabetes had a 3-4 times higher risk of developing liver cancer. This likely occurs because excess fat and blood sugar abnormalities are linked to steatosis (fatty liver), which in turn is associated with worsened fibrosis progression. "Given the current epidemic of obesity and diabetes in the United States," write Mimi Yu and Jian-Min Yuan, "this risk factor will be increasingly important." (Interestingly, however, Dr. Tanaka's team found that HCC was less likely in individuals with higher blood cholesterol levels).

Not surprisingly, people with a combination of risk factors – for example, viral hepatitis plus heavy alcohol use – have an even greater risk of developing liver cancer. In Dr. Tanaka's study, individuals with HCV/HBV coinfection had an HCC incidence of 12%, compared to 3% for those with only HCV and 2% for those with only HBV. Although there is little data so far, people coinfecting with chronic viral hepatitis plus HIV may also be at higher risk for HCC.

Because it causes few symptoms, it is difficult to detect liver cancer during its early stages when it is easier to treat. By the time a patient presents with clinical symptoms, the condition is often advanced and survival is typically measured in months. Researchers are still searching for good non-invasive methods to detect early HCC. Liver biopsy is the "gold standard" for detecting dysplastic (abnormal) or cancerous cells, but frequent biopsies are not practi-

cal for most patients. A chemical called alpha-fetoprotein (AFP) is often elevated in the blood of people with HCC, but levels may be normal in people with small tumors. Elevated AFP can also signal other conditions, so the test is not very reliable. Ultrasound scans can detect liver tumors, but they are expensive and their accuracy depends on the skill of the technician. Researchers are studying several new potential biomarkers for HCC. A study by Valérie Paradis and colleagues, reported in the January 2005 issue of *Hepatology*, found that an algorithm based on six different proteins whose levels differed in cirrhotic patients with and without liver cancer correctly diagnosed HCC about 90% of the time.

Some experts advocate using AFP and/or ultrasound to screen selected at-risk patients for liver cancer, but studies to date have not shown that screening reduces mortality. "[T]here is no definitive evidence that [HCC] surveillance improves patient outcomes," writes Adrian DiBisceglie in the *Gastroenterology* supplement. "Nonetheless, serial measurement of AFP levels in serum and hepatic ultrasound have become routine practice, despite a lack of evidence of their overall benefit."

Liver cancer treatment may include resection (surgical removal), percutaneous ethanol injection (injection of ethyl alcohol into the tumor), and/or transcatheter arterial chemoembolization (injection of chemotherapeutic drugs into the tumor's blood supply). Unfortunately, HCC is difficult to treat and survival rates tend to be low. In advanced cases, liver transplant may be the only option.

Thus, one of the best hopes for reducing liver cancer mortality is preventing or treating viral hepatitis and controlling the long-term

damage it can cause. In the case of hepatitis B, this may be achieved through widespread vaccination. For those already infected, treatment can reduce liver cancer rates. In a controlled trial of 651 Asian subjects with HBV-related cirrhosis, for example, 3.9% of patients treated with lamivudine developed HCC, compared with 7.4% in the placebo arm. According to a review by T. Jake Liang and Theo Heller, small prospective studies and larger retrospective analyses suggest that interferon-based therapy for hepatitis C leads to decreased HCC incidence. In a European study by B. Veldt and colleagues reported in the October 2004 issue of *Gut*, among a cohort of 286 hepatitis C patients who achieved sustained virological response to interferon monotherapy, none developed HCC during more than four years of follow-up, and the overall survival rate was comparable to that of the general population. The current standard-of-care regimen, pegylated interferon plus ribavirin, will likely reduce HCC incidence even more dramatically. Finally, some research indicates that even if hepatitis treatment does not produce sustained virological response, it may still slow or even reverse liver disease progression.

In conclusion, HCC may ultimately prove to be one of the most preventable types of cancer. "[A]pproaches to preventing HCC should focus on eradicating HCV infection, responsible for the inflammation and fibrosis," writes Jenny Heathcote in the *Gastroenterology* special issue, "and also on treating or reducing the modifiable risks, such as through hepatitis B vaccination, decreasing alcohol use, phlebotomy for iron overload, and weight control and diabetes prevention."



How to Start a Support Group: *Part 5*



Alan Franciscus, Editor-in-Chief

SAMPLE SUPPORT GROUP FORMAT

The following is a sample of a group format:

The support group meets on the first and third Monday of every month from 7:00-8:30PM.

Starting the Group (the first 45 minutes)

The first order of business—each member should check-in with the group. The members usually talk about any important issues or just a general “where they are at.”

This allows all members to speak and it is an important part of the meeting for establishing group unity. The check-in for each member is usually 2-3 minutes each, but should not last longer than 5 minutes. During the check-in, group members may ask for additional time to talk about topics or problems they would like to discuss with the entire group. The member checking in should not be interrupted with questions or comments.

The facilitator may also introduce a question into general check-in such as:

“When you check-in, please define how you are feeling” (Discourage members from using “Fine” or other one word simplistic descriptions.)

“When you check-in, please tell us one thing that you feel good about or grateful for.” (It helps group members to start out with a

positive instead of a negative comment. This can also be used for the check-out.)

Education or Specific Topic Section (35 minutes)

The second part of the group is ideal for discussing a wide range of topics. It is important to talk about the various topics and to have the group prioritize and decide which topics should be discussed at each meeting. You may even want to arrange for a speaker to address the group.

Check Out

It is important that each member is able to bring closure to the group meeting. Allow about 5-10 minutes at the end of the meeting for the members to check-out. This is the time for members to have a final word or thought. This could be a simple goodnight or a comment about the meeting. The person checking out should be allowed to talk without interruption.

The ending of the group is important to give the members a positive feeling about group unity and hope for their future. Many groups perform a closing ritual to bring about a sense of group unity and hope. The closing can be a prayer, mediation, poem or holding hands with a moment of silence. Ask the group members what they prefer to close the meeting. Ask the group members to share any prayers or poems they find that helps them.

Examples:

- *Serenity Prayer:*

God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference.
- *Silent meditation:*

All the members form a circle and silently say to themselves:
 - May I be well (breathe in)
 - May Others be well (breathe out)
- *Repeat*

STRATEGIES FOR CHALLENGING SITUATIONS

Every support group is unique. Support group members bring a wide variety of issues and emotions to every group based on the members’ personalities and viewpoints.

At times, personalities and viewpoints will clash with the facilitator and other group members. The facilitator will need to help resolve any potential problems that might arise during the meeting. Try not to worry too much about potential problems – trouble is generally infrequent and by referring to the ground rules and developing strategies beforehand you can avoid or handle most of the problems that may surface during a meeting.

Support Group Members

Since the ground rules (to be discussed in part 6) have been adopted by the other group members most of the problems can be

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resolved by referring to the rules. It is also important to remember that the entire group is responsible for maintaining the harmony of the support group – not just the facilitator.

No one likes to be directly challenged by the facilitator or other group members. If you must interrupt or challenge a member try using a calm and reassuring voice in a non-threatening way. Always try to reassure the person with a positive comment when interrupting or when attempting to refocus the group.

Common Problems

• *Member repeatedly shows up late for the support group meeting*

▪ Acknowledge that the member is late and remind him or her that the member is responsible for showing up on time. Of course, there are always situations that prevent people from arriving on time, so be careful that you are not too rigid.

♦ “I have noticed that you have been late for the last 2 meetings – is there anything we can help you with to make sure you show up on time?”

• *A member is talking too long at check-in*

▪ Remind the member of the ground rules – there is a time limit so that everyone can talk

♦ “It sounds like you may need some time during the group – is there an issue you would like help with from the group after checking-in?”

• *A member is monopolizing the conversation.* A good strategy before this happens is to discuss the dangers of one member

monopolizing the group with the entire group and include it in your group rules.

▪ If the member is monopolizing, rambling or gets side-tracked:

♦ Bring the member back to the main points by summarizing the key points and asking the other group members to comment.

♦ Interrupt the member: “You bring up some interesting points. Do any others have any comments or would others like to share how this relates to them?”

♦ Avoid direct eye contact with the person monopolizing – it is harder for people to monopolize the conversation if the leader is not actively engaged.

• *A group member frequently makes comments or ask questions only to the facilitator*

▪ Look away from the member

▪ Pass the questions back to the group

▪ After the group, talk with the group member about directing comments or questions to the entire group

• *Silent moments*

▪ Silent moments can be a positive sign that members are feeling comfortable with each other. It can also mean that people are digesting information or may be trying to process some feelings. If the silence runs on for too long ask the members “Does anyone have any other thoughts about what was just discussed?” Or you can simply move along to the next topic.

• *The silent member*

▪ It is ok for members to sit quietly and not participate. If you feel that someone wants to talk but may be shy you can make direct eye contact with the quiet member. Check out their body language

for hints that they may want to jump into the discussion. You can also ask them: “Do you have anything you want to share about the discussion?” “It’s ok if you don’t want to comment, but do you have any feelings about what we discussed?”

• *Incorrect information*

▪ Nothing is to be gained by directly or aggressively challenging a member when they state incorrect information. Instead try to speak in a calm and soothing voice:

♦ “Hmm...that’s not what I have heard or read. Maybe we can talk about it after the group.” You can also say (in a non-threatening way) “I have heard differently, let’s talk after group about how we can research this issue and share it with the group at a later time.”

• *Humor – appropriate and inappropriate*

▪ Humor is a wonderful tool to use to break the tension in the group when the conversation becomes too filled with emotions. However, it can also interfere with members coming to terms with emotions and may impede a discussion that is important. Try these strategies:

♦ Ignore the humor and move on.

♦ Make a comment such as, “That was really funny, but I think we need to stick with our discussion.”

♦ If a person continues to interject inappropriate humor say, “This is a serious issue and we really need to concentrate on working through this issue.”

• *Anger*

▪ Anger is a necessary part of the support group process especially for people with a potentially life

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threatening illness. However, it is important that anger be released in a non-threatening way and that it is not directed against anyone in the group. Once anger is verbally expressed a member should be able to move on. However, prolonged anger can sabotage a support group meeting by making people feel that the group is unsafe. If anger continues to dominate a meeting try these approaches:

- ♦ Acknowledge the feelings being expressed by the member
 - “You have expressed some powerful emotions. What does this bring up for the other members?”
 - ♦ Ask for a time-out so that you and the other members can deal with the anger.

• “I can see that you are really upset. Let’s take a couple of minutes before we continue with the discussion.”

• Acknowledge the feeling of the member and reassure the member that everyone wants to help.

♦ If the member becomes too angry, ask them to step outside for a minute and try to calm them down.

♦ Try moving on to another topic, but make sure you come back to the member and check in when the emotions have calmed down a bit.

• *Crying*

▪ Crying is an essential part of the grieving process. If someone starts to cry reassure them that the feelings are normal. If the person is unable to continue to talk, move on to another topic or ask the other

members to check-in. Be sure to always come back to the member after they have stopped crying to check in and ask if they would like to continue talking about the issue.

• *Side talk*

▪ Side talking is very disruptive to the group and it leaves other group members feeling like they are being left out of a personal conversation instead of creating an atmosphere of sharing information and feelings. The best advice is to remind the members at the beginning of the meeting of the ground rules and enforce the rules when appropriate. A facilitator may have to stop the group for a moment to make the point or interrupt the members and ask them if they want to share.



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HealthWise:

Aspirations, Occupations, and HCV



Lucinda K. Porter, RN, CCRC

Recently I received an email from a reader who has dreams of becoming a nurse. She writes, "I've been afraid that at the point of job placement maybe I wouldn't be hired because of my HCV (hepatitis C virus) status." The writer asks if this is a real or "made-up" fear.

There are many aspects to this inquiry. There is the practical issue – can people who are HCV positive work in the health field? Do healthcare workers with HCV present any risk to their patients? If so, are there ways to prevent or reduce that risk? Are HCV-positive healthcare employees required to disclose their health status? Are there any ethical considerations regarding this issue? How does one deal with the stigma that is sometimes attached to HCV? And finally, there is the issue of HCV interfering with patients' hopes and dreams.

As unsettling as it may sound, people with HCV can work in the health field. This includes doctors, surgeons, nurses, and phlebotomists. A patient without HCV may find this disturbing, but let's explore this issue. The term nosocomial is applied to infections that patients acquire in a healthcare setting. The sources of infection can include equipment as well as people. All healthcare facilities are required to follow very strict guidelines in order to prevent nosocomial infections. These guidelines serve to protect both patients and healthcare employees. The required precautions are standardized. The Centers for Disease Control and Prevention (CDC) acknowledges that "nosocomial transmission of HCV is possible if infection-control techniques or disinfection procedures are inadequate and contaminated equipment is shared among patients. Although reports from other countries

do document nosocomial HCV transmission, such transmission rarely has been reported in the United States, other than in chronic hemodialysis settings." The risk of infection for hemodialysis patients comes from other patients and the sharing of contaminated medical equipment. There have not been any documented cases in the United States of patients acquiring HCV directly from healthcare personnel in the hemodialysis setting.

An interesting and important fact is that the prevalence of HCV infection among healthcare personnel is the same as the general population (1.8%). This figure includes all who work in the healthcare field, including surgeons. This supports the notion that infection avoidance precautions do work and in fact, work quite well. Since all personnel are required to follow these precautions, then HCV-positive healthcare workers prevent transmission of HCV when they follow these procedures.

The CDC makes no recommendations to restrict HCV-positive healthcare personnel. Disclosure of HCV is not required in order to work in the medical field. It is illegal to discriminate against employees based

solely on their HCV status. For medical personnel who are exposed to HCV-infected blood, the CDC does not require any special precautions other than to "refrain from donating blood, plasma, organs, tissue, or semen" during the follow-up period. Patient care responsibilities do not need to be modified.

All of this is encouraging, but it does not absolve an HCV-positive employee of responsibility or ethical consideration. It is essential that standard

*"Yes, you can be a nurse.
In fact, you may be a
better nurse than most
because of having HCV."*

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precautions are followed consistently, which is required of all health-care personnel. In short, it is the moral and medical responsibility of all health-care personnel to protect their patients from harm.

The issue of stigma is much more difficult to address. Stigma is linked to ignorance and fear, both of which are deeply-rooted social problems. HCV is stigmatized for a number of reasons. There is the fear of transmission, although in most everyday circumstances, few of us engage in behaviors that put us at risk. The association of HCV with injection and nasal drug use also stigmatizes HCV. It is interesting to me how many people feel ashamed they have HCV, regardless of the origin of infection. It is common for people living with HCV to describe themselves as feeling “dirty” or “contaminated.” Stigmas hurt all of us, because they divide rather than unite.

Because of the fear of infection, I do not recommend that medical personnel disclose their HCV status, except when it may serve their patients. For instance, it may be appropriate to disclose your status if you work with HCV patients. However, it would be inappropriate to broadcast this information while working in a neonatal unit. Also, if infection control precautions are breached and you believe you may have placed a patient at risk, it is absolutely mandatory that you follow the procedures set forth by your place of employment. This is non-negotiable. Although it would cause great pain knowing we may have infected another person,

keep in mind that transmission rates from needle sticks are low and that acute HCV can be treated successfully if treated properly.

As for dreams, an HCV diagnosis is not what any of us had planned. Having a chronic illness, especially one that is potentially contagious, can be humbling. HCV reminds us of our mortality. Those who deal with HCV symptoms, treatment, and the side effects of antiviral therapy may have felt that their aspirations were hit by a steamroller. However, sometimes HCV can motivate us to live beyond our dreams and to have a life even bigger than our imagination. So, to the person who wrote to me, I say this, “Yes, you can be a nurse. In fact, you may be a better nurse than most because of having HCV. Sometimes the wounded make the best healers.”

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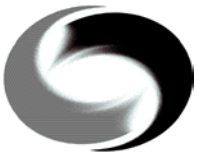
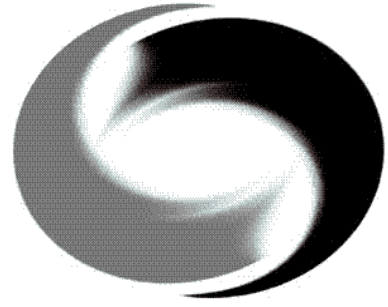
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