# ashm DECISION MAKING IN HEPATITIS C

## 1 When To Test

# 2 Test/s, Results and Actions

#### **Clinical Indicators**

- Abnormal liver function tests (LFTs) (males, ALT ≥ 30 U/L; females, ALT ≥ 19 U/L)
- Jaundice

#### Presence of Risk Factors

- · Injecting drug use (current/ever)
- Sharing of snorting equipment
- · Born in high prevalence region^
- Blood transfusions and blood products before 1990 in Australia
- Unsterile tattooing/body piercing
- Unsterile medical/dental procedures/blood transfusions in high prevalence countries
- Time in prison
- Needlestick injury
- Mother to child transmission
- Sexual transmission in men who have sex with men (MSM)
- Sexual transmission in those who are HIV positive
- People living with HIV or HBV infection

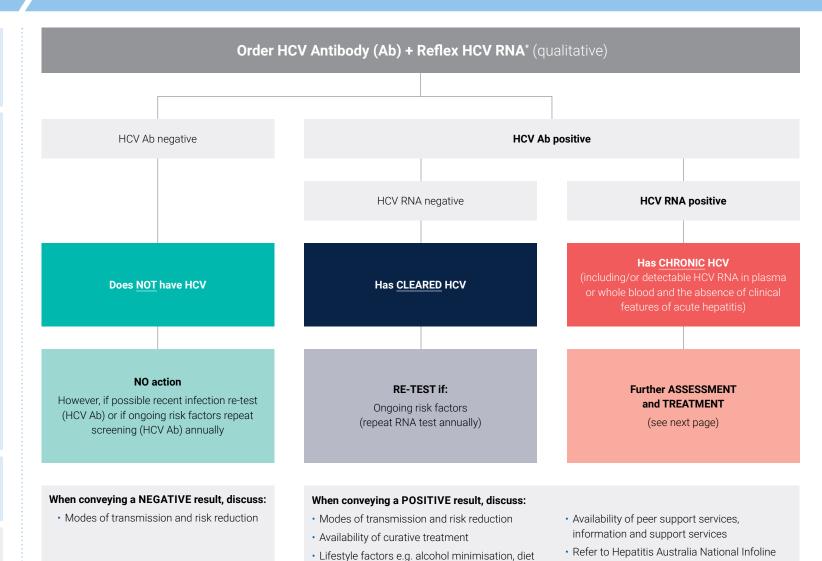
^Africa, the Middle East (in particular Egypt), the Mediterranean, Eastern Europe, and South Asia

#### Other

- · Initiating PrEP
- · When someone requests a test

# When gaining informed consent before testing, discuss:

- Reason for test
- · Availability of curative treatment



\*If high level suspicion also consider requesting reflexive HCV RNA (ordering HCV Ab + HCV PCR if HCV Ab is positive) + LFTs

1800 437 222

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### **3** Pre-Treatment Assessment

# 4 Treatment

# **5** Monitoring

# 6 Follow Up

#### Baseline screening after positive HCV PCR

- ☐ LFTs (including AST) and INR
- ☐ Full Blood Count
- ☐ Urea, electrolytes, creatinine

#### Assess liver fibrosis: cirrhotic status

- ☐ Signs of chronic liver disease (spider naevi, palmar erythema, jaundice, encephalopathy, hepatomegaly, splenomegaly, ascites, peripheral oedema)
- □ Non-invasive assessment of fibrosis: <a>⊗</a>
  - Serum biomarkers such as APRI (<1.0 means</li> cirrhosis unlikely). Calculator available hepatitisc.uw.edu/page/clinical-calculators/apri
  - Elastography assessment e.g. Fibroscan® (>12.5 kPa consistent with cirrhosis)

#### Check for other causes of liver disease

- ☐ Check for viral coinfection:
- HIV Ab/Ag
- Hepatitis A check hep A IgG; vaccinate if negative
- Hepatitis B check HBsAq, anti-HBc and anti-HBs; vaccinate if all negative
- ☐ Heavy alcohol intake
- ☐ Fatty liver disease check weight, BMI

#### Check for other major co-morbidities

☐ Renal impairment (eGFR < 50)

#### **Review previous HCV treatment**

· Choice/length of treatment may be influenced by prior HCV treatment experience/response (2)

#### Consider pregnancy and contraception

 HCV treatment not recommended for use in pregnant or lactating women

#### For more information www.hepcguidelines.org.au

~SOF/VEL = Sofosbuvir/Velpatasvir; GLE/PIB = Glecaprevir/Pibrentasvir @ASHM 2023 ISBN: 978-1-921850-67-7

Recommendation for treatment now includes all people with a risk factor for hepatitis C transmission who are found to have detectable HCV RNA in plasma or whole blood, regardless of the duration of infection.

# Is your patient likely to have cirrhosis? □ Yes □ No Discuss with or refer to a specialist# Has your patient received previous treatment for HCV?

# ☐ Yes □ No Discuss with or refer to a specialist#

Tre	atment	Dosage	Duration if no cirrhosis present	Duration if compensated cirrhosis (Child Pugh A) present
	F/VEL~ clusa®)	400/100mg Once-daily (1 pill)	12 weeks	12 weeks
	E/PIB~ aviret®)	100/40mg per pill Once-daily (3 pills)	8 weeks	8 weeks <sup>†</sup>

☐ Check for drug-drug interactions at hep-druginteractions.org ☐ Call the PBS Authority Script Line (1800 020 613) for approval

Consult with your local specialist or complete the online remote consultation form at reach-C.ashm.org.au (turn-around time <24 hours).

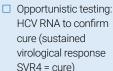
# All patients with cirrhosis or prior HCV treatment experience should be reviewed by someone experienced in hepatitis C treatment. If cirrhosis is suspected (APRI ≥ 1.0 or elastography > 12.5 kPa), further evaluation is required before commencing treatment.

† A treatment duration of 12 weeks may be considered for patients with compensated cirrhosis at the discretion of the prescriber.

#### Monitoring while on treatment

- · Generally not required but approach should be individualised
- HCV treatment are generally minimal
- Dose interruptions should be managed according to duration and DAA therapy completed (Refer to Hepatitis C Consensus Statement)

### 4-12 weeks post (2) treatment



☐ LFTs

- Side effects of



#### If your patient has no cirrhosis and normal LFT results (males, ALT< 30 U/L; females, ALT < 19 U/L) ALT = alanine aminotransferase

No clinical follow-up for HCV required

#### If your patient has ongoing risk factors

Annual HCV RNA test. If re-infected, offer re-treatment and harm reduction strategies

#### If your patient has abnormal LFT results



(males, ALT  $\geq$  30 U/L; females, ALT  $\geq$  19 U/L) Evaluate for other causes of liver disease and refer to specialist for review

### If your patient has cirrhosis



Refer to specialist. Patients with cirrhosis require long-term monitoring:

- 6-monthly abdominal ultrasound (hepatocellular carcinoma screening)
- Consideration of screening for oesophageal varices
- Osteoporosis: 2-yearly DEXA scans and monitor serum vitamin D
- Assess risk of clinically significant portal hypertension (elastography, PLT)

### **CONSULT WITH A SPECIALIST IF:**

#### Pre-treatment

- Prior treatment failure of HCV treatment
- elastography >12.5kPa

#### **During treatment**

#### Post-treatment

Disclaimer: Guidance provided on this resource is based on guidelines and best-practices at the time of publication. This quick-reference quide is not intended to be a comprehensive list of all available options. Refer to the General Statement for Drugs for the Treatment of Hepatitis C for all current PBS-listed regimens.