UNIVERSAL SCREENING FOR HCV

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CHRONIC HCV
GOAL OF SCREENING

- Primary:
  - Identify persons with chronic HCV
  - Confirm infection in persons who screen positive
- Secondary:
  - Evaluate persons with HCV infection for treatment
  - Initiate treatment of HCV
  - Document response to treatment
  - Prevent reinfection

CHRONIC HCV
TYPES OF SCREENING PROGRAMS

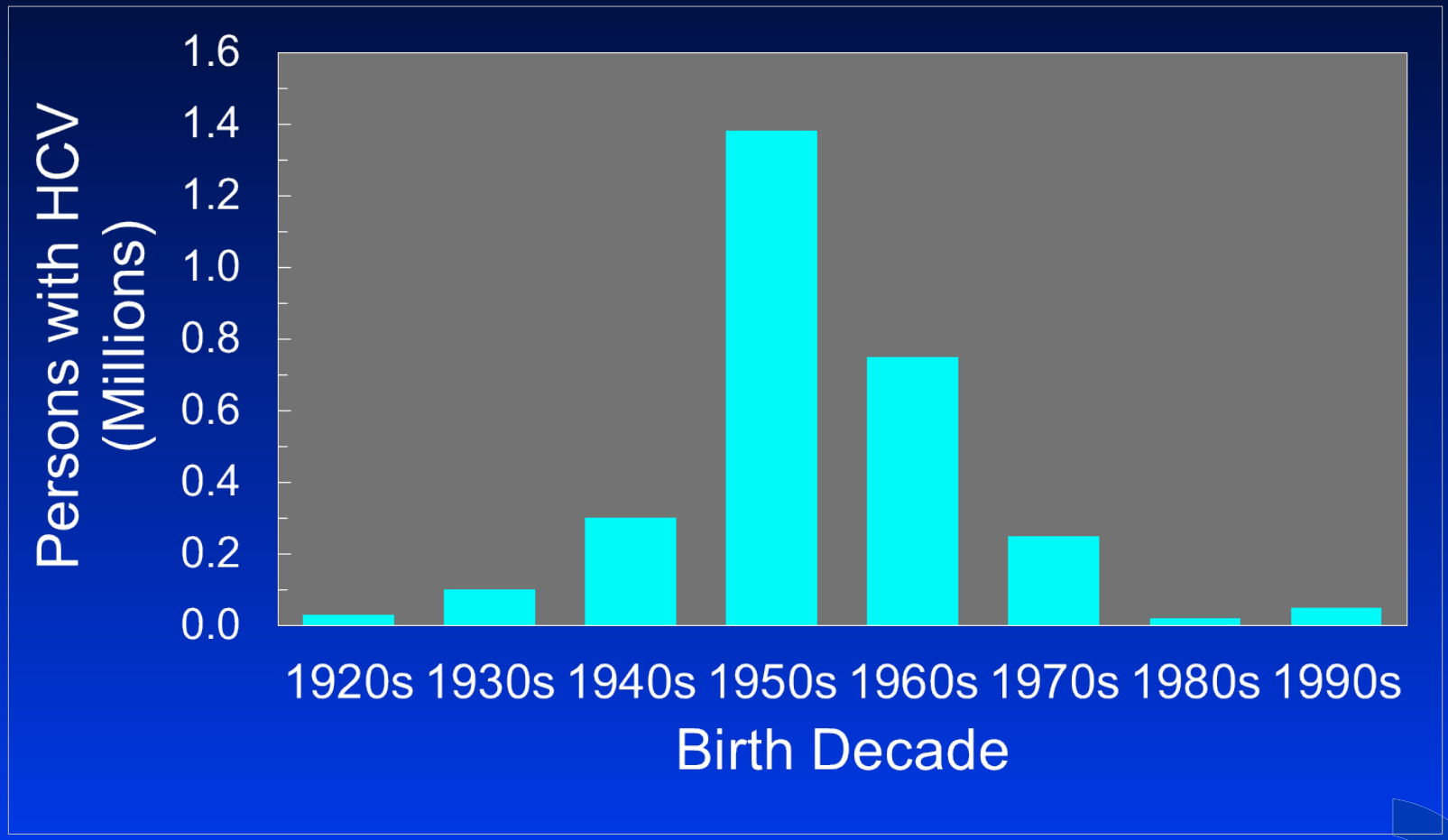
Cohort Based Screening

- Define cohort
- Birth years 1945-1965
- Highest disease prevalence
- Lower yield per screen
- Miss those outside cohort

Risk Factor Screening

- Requires specific knowledge
- Physicians don't ask
- Patients don't tell
- Highest yield per screen
- Identifies fewest patients

CHRONIC HCV
BIRTH COHORT SCREENING



BD Smith et al.

Am J Public Health 2014; 104:474-481.

CHRONIC HCV SCREENING RECOMMENDATIONS

Center for Disease Control

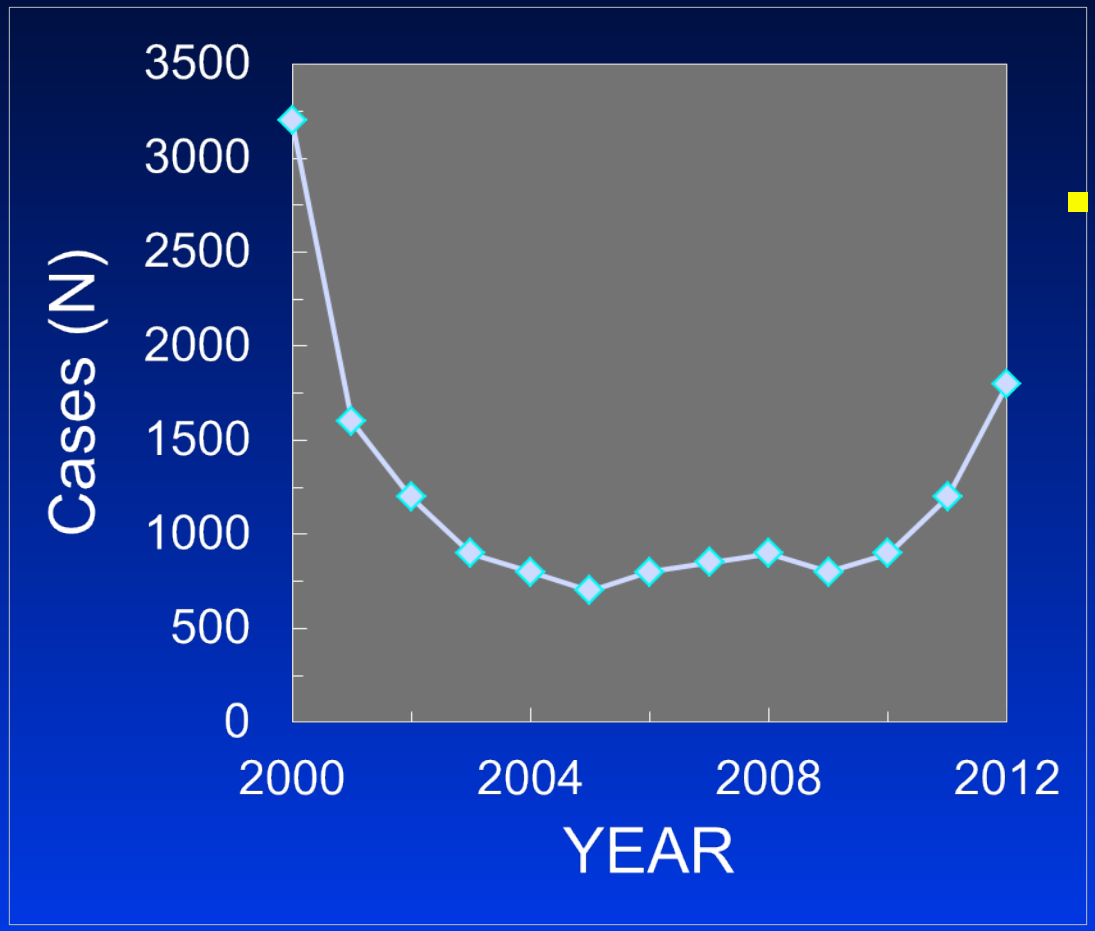
- All adults born from 1945-1965 should receive one time screening for HCV
- If HCV positive:
  - Alcohol screening and intervention
  - Referral for appropriate HCV care

US Preventative Services Task Force

- The following persons should be screened for HCV:
  - Persons at high risk for HCV infection
  - Persons born from 1945-1965

VA Moyer. Ann Intern Med 2013; 159:349-357.
BD Smith et al. Ann Intern Med 2012;157;817-822.

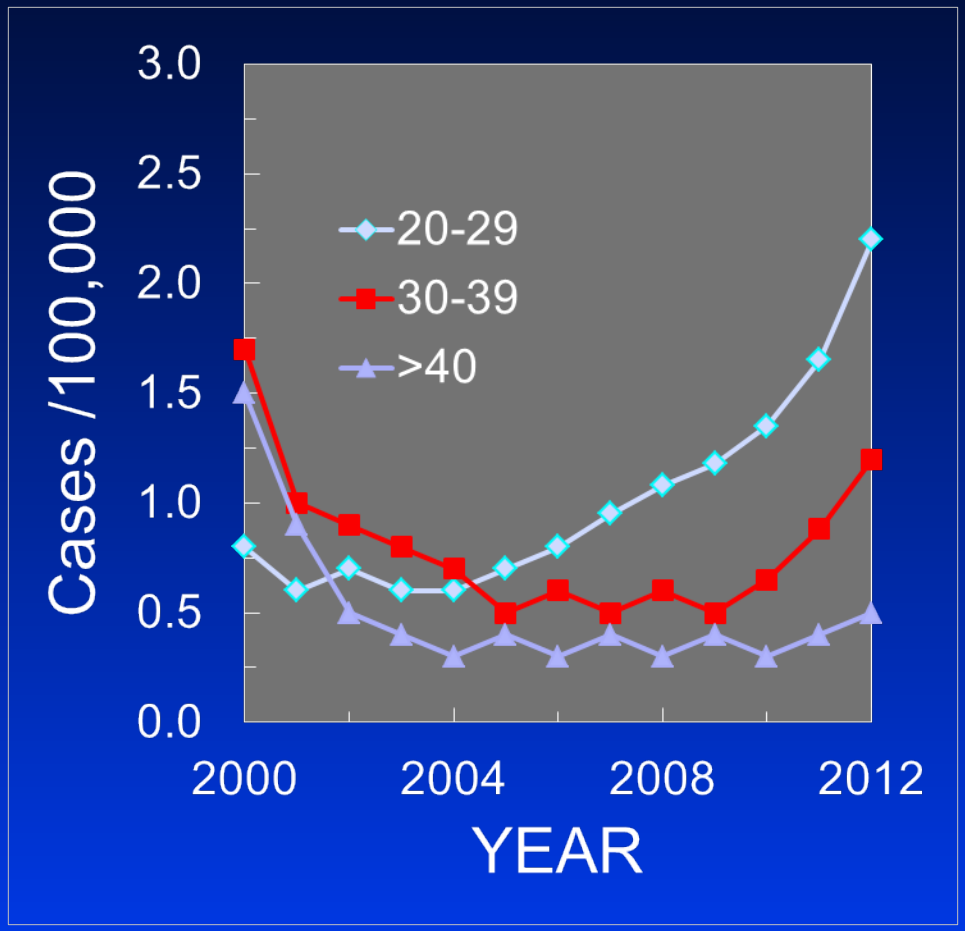
ACUTE HCV
INCREASING INCIDENCE SINCE 2010



- The increasing incidence of acute HCV is due to a resurgence of IV drug use which is most commonly seen in young persons between the ages of 20-39 years

National Notifiable Diseases Surveillance System (NNDSS)

ACUTE HCV
RISING RATE IN YOUNG ADULTS



- Age cohort based screening would exclude those patients with the highest prevalence today.
- Age range 20-39 years
- Birth years 1975-1995

National Notifiable Diseases Surveillance System (NNDSS)

CHRONIC HCV
TYPES OF SCREENING PROGRAMS

Universal Screening

- Screen all persons
- When to screen
- Where to screen
- Lowest yield per screen
- Highest cost

Cohort Scree

- Define cohor
- Birth years 1945-1965
- Highest disease prevalence
- Lower yield per screen
- Miss those outside cohort

Risk Fact Scree

- Requires sp
- Physicians don't ask
- Patients don't tell
- Highest yield per screen
- Identifies fewest patients

UNIVERSAL SCREENING
HOW DO WE DO THIS?

- When to screen
  - 30th birthday?
  - On a persons birthday?
  - Mass screening for all on a set day?
- Where to screen
  - Screening station?
  - Medical establishment?
- Excluded from screening
  - Age cut-off?
  - Health cut-off?
- Mandatory vs Voluntary

HCV SCREENING
WHAT IS THE RIGHT TARGET

- Universal screening is the eventual goal
- But impractical to accomplish in a limited period of time
- Birth cohort screening combined with Targeted screening of:
  - Intravenous drug users
  - HIV infection
  - ESRD entering dialysis
  - Incarceration
  - Immigrants from high risk areas

THE REAL PROBLEM
LINKAGE TO TREATMENT

HCV Pool
~3.2 Million

⇩

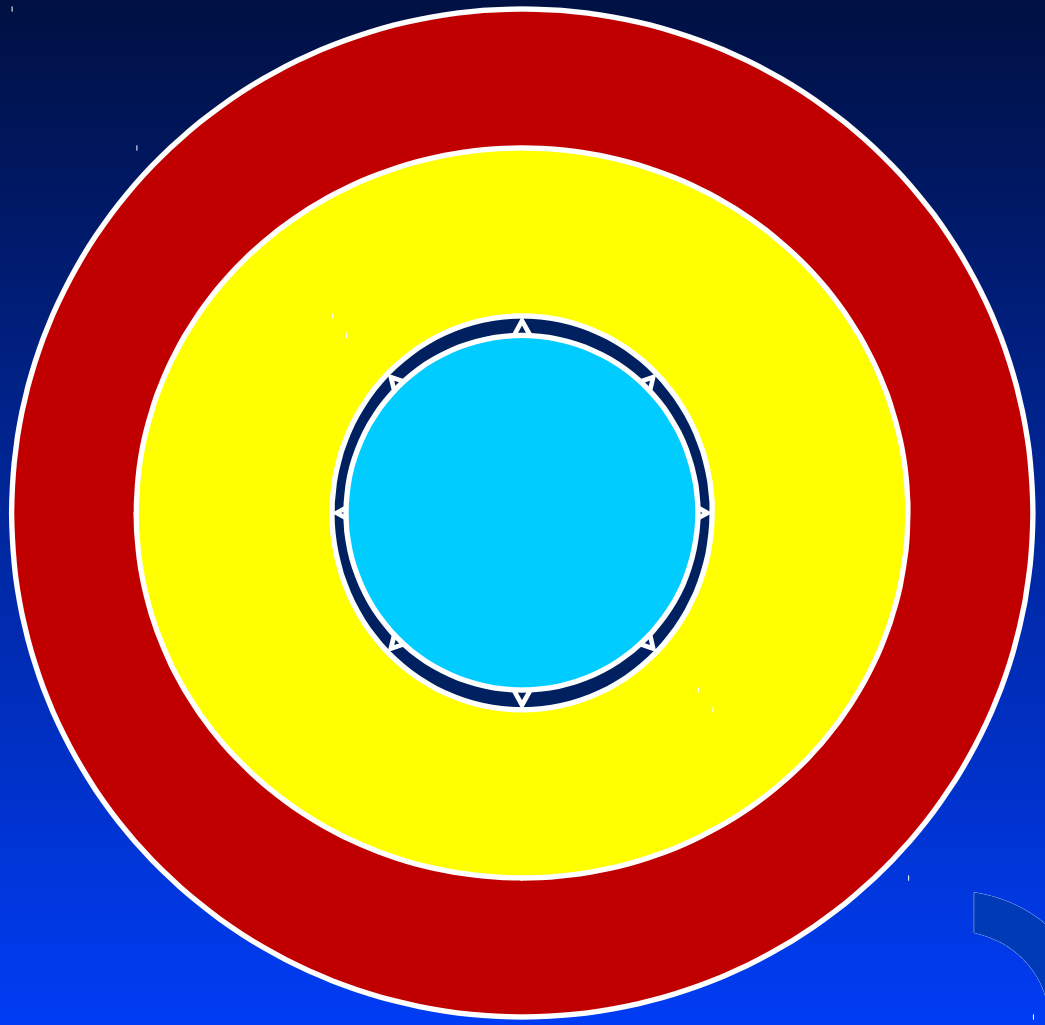
Detected: 50%

⇩

Treated: 9%

⇩

SVR: 6%



MM Denniston et al.
Ann Int Med 2014; 293-300.

THE REAL PROBLEM
LINKAGE TO TREATMENT

HCV Pool
~3.2 Million

↓

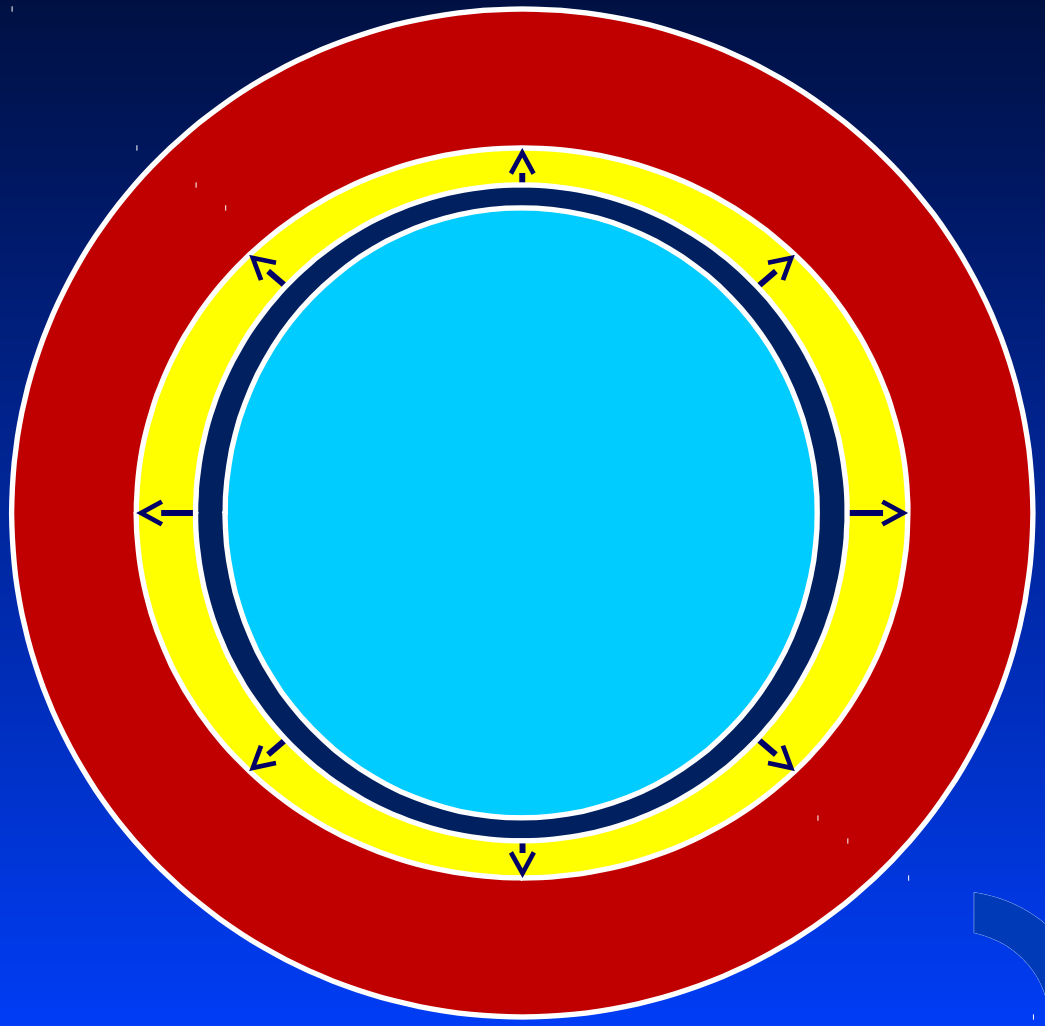
Detected: 50%

↓

Treated: 40%

↓

SVR: 37%



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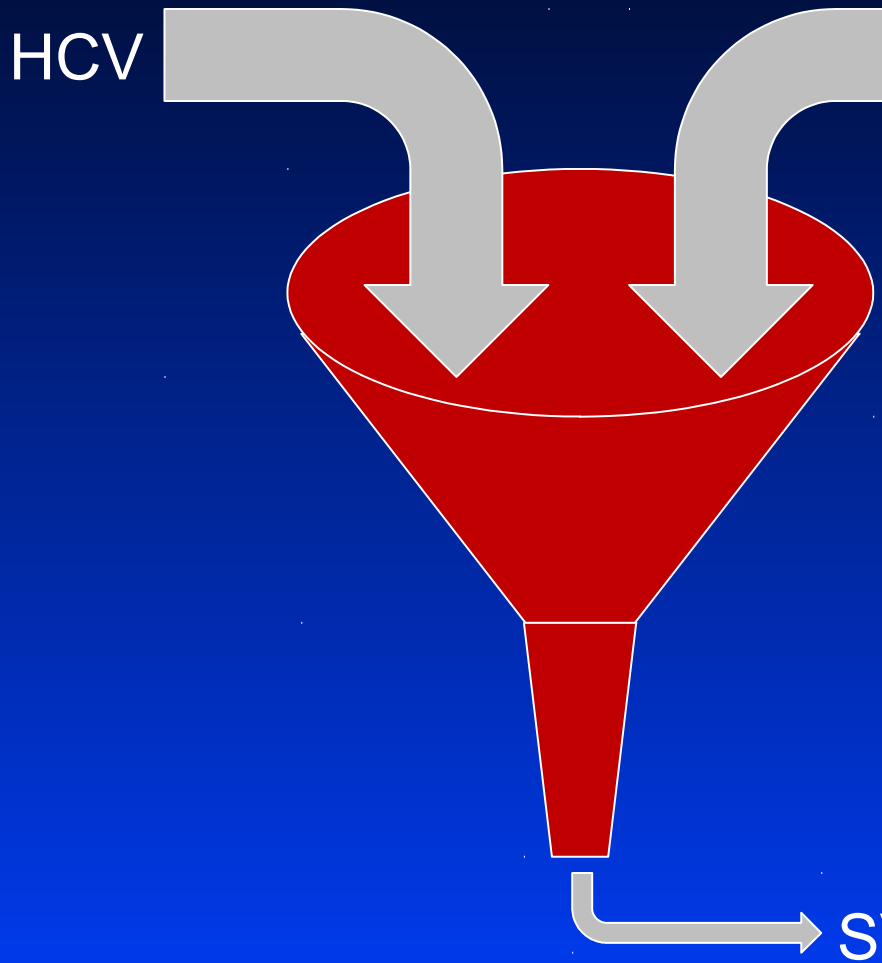
UNIVERSAL SCREENING
THE REAL LIMITS TO TREATMENT



- The limitation is not HCV patients who need treatment.
- It is the restrictions to treatment imposed by insurance carriers and many government health agencies.
- Universal screening would only cause the funnel to overflow.

UNIVERSAL SCREENING FOR HCV CO-MORBIDITIES

- Allows for identification of co-morbidities even when HCV cannot be treated.
- Enhance fibrosis progression
- Limit fibrosis regression after SVR
- HIV
- HBV

  - Should be evaluated and treated
- Alcohol: “safe” alcohol intake before and after SVR?
- NAFL:
  - Consider when features of metabolic syndrome present
  - Consider liver biopsy if liver transaminases remain elevated after SVR

ML Shiffman
Liver Int 2016; 36 (Suppl S1):62-66.

PATIENTS IN WHOM HCV TREATMENT SHOULD/MAY NOT BE CONSIDERED

- Acute HCV
  - 15-20% spontaneous resolution
  - Treat if develop chronic disease
- Life limiting co-morbidities and mild hepatic fibrosis
- Active intravenous drug users with no plans to curb these activities:
  - Risk of reinfection 5-10% annually
  - Risk of death from drug use 1.7% annually
  - These patients have 2 severe diseases:
    - HCV
    - Drug addiction

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UNIVERSAL SCREENING SUMMARY

Universal screening for HCV
Is not as easy as 1, 2, 3
Testing every man, women and child
May take awhile
And if negative do we ever check again
And if so why and when

What screening does due for all
Is allow us to address another ball
Be it NAFLD or alcohol

UNIVERSAL SCREENING SUMMARY

For years we screened those with risky behaviors
Then age based screening became the savior

But is identifying more patients really the issue

Half the patients we already know
And they are more than eager to join the show
But they cannot get treated without some dough
Because those DAMN payers are still saying NO

UNIVERSAL SCREENING SUMMARY

So until the payers have less to fear
All we can do is lend an ear
Maybe things will be better in the coming year
When are options grow with Zepatier