Is There Any Good Reason Left to Delay Hepatitis C Treatment?

Physicians increasingly argue that the best choice is to get rid of hepatitis C right away. But your insurance company may not agree. How risky is it to wait for treatment?

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In the old days of hepatitis C virus (HCV) treatment, people looking to shoot for a cure had to weigh the dreadful side effects of lengthy interferon therapy against the uncertainty that the drug, along with ribavirin, would even clear the virus. Often included in this calculation was the question of whether hep C had caused sufficient liver damage to justify the risks of a highly toxic treatment with only a middling success rate.

Today, most Americans with hep C are looking at a greater than 90 percent chance of ridding themselves of the virus after only 12 weeks on medications that have minimal side effects. Some people can get away with only eight weeks on therapy, although others will require 24 weeks.

With such powerful and tolerable hep C drugs on the market, are there any major medical reasons left to delay a cure?

“I would argue that everyone with HCV should seriously consider seeking treatment,” says Benjamin Linas, MD, an assistant professor of infectious disease medicine at Boston University, expressing a common sentiment.

Unfortunately, for HCV-positive individuals who have more minimal or non-existent liver damage, the timing of their treatment may not be up to them. In an attempt evade some of the astronomical expense of the new hep C drugs, state Medicaid programs, as well as some private insurers, have instituted policies restricting reimbursement only to those with later stages of liver disease.

The American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) have issued guidelines that outline which groups of HCV-positive people should be prioritized for treatment in the event that financial resources are limited. This has been a controversial move, one that activists have criticized as effectively providing cover for rejection-happy insurers.

Raymond Chung, MD, director of hepatology at Massachusetts General Hospital in Boston and co-chair of the advisory panel that created the hep C treatment guidelines, stresses, “To be sure, the most important and guiding principal here is that all patients should be treated. In an ideal world, it would make a great deal of sense to treat patients irrespective of their liver disease.” When constructing the guidelines, the panel needed to walk a fine line between advocating for such universal treatment and ensuring, in the event that cost considerations will limit the number of people who can be treated, that those who need treatment more urgently will receive it first. The ultimate goal is to save as many lives and reduce as much hep C-related disease as possible with the resources that are currently available.

At the top of AASLD and IDSA’s priority list are individuals with advanced liver fibrosis (scarring of the liver), compensated cirrhosis (the advanced stage of liver disease that follows the highest level of fibrosis), liver transplants, and those with severe cases of other non-liver-related health conditions that hep C can trigger. Next, the guidelines give higher priority to those who have: HIV or hepatitis B virus (HBV) coinfection; moderate fibrosis; another form of liver disease, such as nonalcoholic steaohepatitis (NASH); debilitating fatigue; insulin-resistant type-2 diabetes; or a liver condition known as porphyria cutanea tarda (PCT) that can lead to skin blisters, among other skin problems.

The reason people with these conditions are prioritized for treatment is because they have a greater risk of developing severe complications from hep C, including cirrhosis, liver cancer, liver failure, and death. An immediate cure is likely to reduce their likelihood of these outcomes to a greater extent than for those who, for example, have only minimal or nonexistent fibrosis.

The flip side of this calculation is that, while a cure for hep C typically halts fibrosis progression and can in fact dial back liver damage, waiting for the virus to sufficiently damage the liver before starting treatment likely raises the risk of future complications. A growing body of research suggests that a curing hep C when someone has advanced fibrosis or cirrhosis reduces but does not eliminate the risk of further deterioration of the liver or liver cancer.

True, the virus does typically take decades to cause major damage. And those who have only minimal scarring tend to progress relatively slowly up the fibrosis scale; the process eventually accelerates if they develop greater scarring of the organ. So there may yet be a good deal of time to consider treatment options or to wait for a more favorable insurance climate without a lot of worry that some delay will make any great difference to an individual’s long-term health prospects.

There are various factors that will raise the risk of accelerated liver damage among those with hep C, including coinfection with HIV, injection drug use, alcohol abuse, obesity, and being older.

Nevertheless, there is never any way to know for sure how any one person’s health may progress over time. “There are certainly no iron-clad predictors,” Chung says. Your liver health may remain stable quite some time, only to hit a period of rapid decline in between check-ups.

However, mitigating liver damage is not the only reason to get rid of hep C. The virus is also linked to a variety of quality of life problems, including fatigue, depression and cognitive impairment, each of which may improve after a cure. Additionally, hep C can contribute to other health conditions, such as diabetes, kidney disease and cardiovascular disease.

And of course there is always the risk of transmitting the virus to others, most notably through needle sharing. Men who have sex with men (MSM), may also transmit the virus sexually (sexual transmission among heterosexuals is rare), particularly to HIV-positive sexual partners. On the flip side, such individuals may also have a higher risk of becoming reinfected with hep C.

As non-toxic as they are when compared with interferon and ribavirin treatment, the current crop of hep C therapies may still as-yet revealed toxicities, leading to short- or long-term risks. Sometimes years need to pass before all the potentially harmful effects of a new drug come to light. Gilead recently announced, for example, that nine people taking Sovaldi or Harvoni (ledipasvir/sofosbuvir) along with the heart medication Cordarone (amiodarone) suffered low heartbeats, with one experiencing a fatal caridac attack arrest. So people considering hep C treatment may still want to weigh the benefits of a cure against theoretical harms.

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