Hepatitis C News: EASL Recommendations on Hepatitis C Treatment

April 15, 2014 By Lucinda K. Porter RN

The 2014 International Liver Congress, hosted by the European Association for the Study of the Liver (EASL) is over, and what a week of news. I will begin with the *EASL Recommendations on Treatment of Hepatitis C* 2014. Here is a link to view the EASL Hepatitis C recommendations; click here to download the recommendations. Here are some highlights:

- "The goal of therapy is to eradicate HCV (hepatitis C virus) infection to prevent hepatic cirrhosis, decompensation of cirrhosis, HCC (hepatocellular carcinoma), and death." EASL recommends using a sensitive viral load assay (<15 IU/ml) at 12 and 24 weeks after the end of treatment.
- Eliminating hepatitis C reduces the rate of decompensation in patients with cirrhosis. HCC risk may be reduced, but it is still a possibility, so patients need to have regular HCC screening even if they are hepatitis C-negative.
- **Non-invasive methods of examining the liver should be used initially;** liver biopsy should be reserved for cases where there is uncertainty or potential other causes of liver disease.
- IL28B genotyping has no role in the indication for treating with the new hepatitis C directing-acting antivirals (DAAs).
- **Anyone with hepatitis C should be considered for treatment, regardless of current stage of liver disease or past treatment.** (Isn't this a wonderful statement!) Priority should be given to patients with significant fibrosis (METAVIR score F3 to F4); patients with moderate fibrosis (METAVIR score F2) may be treated, and timing/indication may be individualized for

patients with no or mild disease (METAVIR score F0-F1). Patients with decompensated cirrhosis awaiting liver transplantation should be considered for interferon-free and ideally ribavirin-free therapy.

- For patients on the triple combination of pegylated interferon, ribavirin and simeprevir, treatment should be stopped if HCV RNA level is â¥25 IU/ml at treatment week 4, 12 or 24. There are no other stopping rules for other treatment regimens. (My note: except when severe side effects prevent taking the medication safely.)
- The EASL guidelines give multiple options for treating the various hepatitis C genotypes. There are at least six options for genotypes 1 and 4. Europeans have the option of using daclatasvir, an NS5A replication complex inhibitor that may be available in the U.S. at the end of 2014. It is clear the pegylated interferon is on its way out, and ribavirin is not long behind it.
- Patients with HCV/HIV co-infection have the same treatment recommendations as those with HCV mono-infection. The treatment regimens are the same with added cautions for patients taking simeprevir--these patient need to beware of potential drug-drug interactions, especially cobicistat-based regimens, efavirenz, delavirdine, etravirine, nevirapine, ritonavir, and any HIV protease inhibitor, boosted or not by ritonavir. (Note: There were also dose adjustment recommendations for HIV patients taking daclatasvir.) **“No drug-drug interaction has been reported between sofosbuvir and antiretroviral drugs.”**
- The same hepatitis C treatments can be used in people who inject drugs (PWIDs) as in people who don’t. Interferon-free treatment may be considered. Sofosbuvir and simeprevir can be used in PWIDs on opioid substitution therapy.
- Acute hepatitis C is treated with pegylated interferon for 24 weeks. Acute cases may also be treated with ribavirin and pegylated interferon. Although there are no data on treating acute hepatitis C with interferon-free therapies, theoretically these would work.

Other hepatitis C guidelines:

- The American Association for the Study of Liver Diseases and the Infectious Diseases Society released *Recommendations for Testing, Managing, and Treating Hepatitis C*

- World Health Organization's *Guidelines for the Screening, Care and Treatment of Persons with Hepatitis C Infection*

In upcoming blogs, I will cover the new hepatitis C treatments announced at EASL. Stay tuned.

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